FAQs

If you have a specific question, see if it's in the list below and click on the link to be taken directly to the answer you're looking for. Otherwise, feel free to browse and scan the FAQs at your own pace.

Your Benefits Marketplace

1. Why is dsm-firmenich moving our benefits?

As we look toward the new year, our employees across the U.S. will experience and be eligible for the same comprehensive lineup of health and wellness programs. This alignment gives us the opportunity to ensure all employees, regardless of location, have access to consistent, high-quality benefits. It also allows us to offer increased flexibility and choice, recognizing the diverse needs and preferences of our workforce.

Additionally, U.S. employers' health care costs have grown significantly in recent years and, without action, would continue to increase rapidly in coming years. Our experience at dsm-firmenich has been no less dramatic. This new approach will help slow the upward trend of health care costs, by making insurance carriers compete for your business.

We remain committed to helping employees pay for health care coverage through a credit. We've taken this moment to review market trends and make thoughtful enhancements where possible, ensuring our offerings continue to support the physical, mental, and financial wellbeing of our teams.

There are several reasons why your benefits marketplace is an attractive solution:

- The plans are fully insured. That means the insurance carriers—**not** dsm-firmenich—are responsible for the cost of claims. We'll show our commitment to helping employees pay for health care coverage through a credit. Since the amount of the credit will not change during the year, our health care spending will be much more predictable. Offering a credit also ensures our benefits remain affordable to you.
- This approach will help slow the upward trend of health care costs. By making insurance carriers compete directly for your business, instead of competing for our business as a company, they have more incentive to offer their best possible price.
- Buying health care coverage through a benefits marketplace also gives you more choice, since dsm-firmenich no longer has to choose options based on what's most affordable and best suited to the general needs of our population. Now you'll have more control over the coverage you choose.

2. What is your benefits marketplace?

Your benefits marketplace is a way for you to get medical, dental, vision, and other coverage. It is a way for you to shop for coverage from multiple health insurance carriers who are competing for your business. It merges the best of both worlds: group rates with more individual choice and price competitiveness that comes from free-market competition.

Your enrollment experience is designed to be easy to navigate and, just like other online stores, you'll be able to see all your options and sort by the features that are most important to you. By the time you complete your enrollment, you should feel confident that you've selected the right coverage options for your circumstances and budget.

3. What are the advantages of your benefits marketplace?

The medical and prescription drug, dental, and vision benefits available offer you:

- **Lots of choices.** Traditionally, you got to choose from the limited health plan options offered by the company. Now, you're able to choose from several coverage levels, a variety of insurance carriers, and a range of costs.

- **Competitive pricing.** The insurance carriers are competing for your business. So it's in their best interests to offer their best prices. Plus, dsm-firmenich will provide a credit to use toward the cost of medical, dental, and vision coverage.

In addition, you have the option to enroll in other valuable benefits—including supplemental life insurance, supplemental accidental death and dismemberment (AD&D) coverage, spouse and child life insurance, supplemental long-term disability coverage, critical illness insurance, hospital indemnity insurance, accident insurance, legal services, and identity theft protection. Also, you can get discounted rates for auto and home insurance and pet insurance.

You also have help when you need it. There are great tools and resources to help you every step of the way. See question #4 for details.

4. Where can I get more information?

There are lots of resources available to help before, during, and after enrollment.

Before and during enrollment:

- **Make It Yours website** (first available with 2026 information on October 29)—Visit **dsm-firmenich.makeityoursource.com** to learn about your coverage options and choosing the right coverage for you and your family.
- **Your Carrier Connection** (available through the Make It Yours website)—Visit each carrier's preview site to get up to speed on provider networks, prescription drug information, and other carrier resources.
- **The My dsm-firmenich Benefits Website and Alight Mobile app** (first available November 17)—When it's time to enroll, log on to the My dsm-firmenich Benefits website at **mydsm-firmenichbenefits.com** or the Alight Mobile app (available through the Apple App Store or Google Play) to compare your options and prices, use helpful decision support tools like Help Me Choose, and enroll.

  Questions? Once logged on to the My dsm-firmenich Benefits website, look for the "Need Help?" icon to ask your virtual assistant any questions you may have. It can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through the My dsm-firmenich Benefits website. You can also call the dsm-firmenich Benefits Center at **855-dsm-fir0 (855-376-3470)** from 8:00 a.m. to 5:00 p.m. ET, Monday through Friday.

Managing your benefits beginning January 1:

- **Make It Yours website**—Visit year-round for practical tips that help you and your family get the most out of your benefits. Get "**The Inside Scoop**" on how to work the health care system, be a savvy shopper, and save money.
- **Your Carrier Connection** (available through the Make It Yours website)—Take advantage of the tools, resources, and information offered through your insurance carrier. For questions about your coverage, always start with your carrier.
- **Your carrier's mobile app and member website**—All carriers have mobile apps and member websites that connect you to a host of tools and resources including virtual care, mental health and wellbeing programs, and tools to look up potential costs for care.
- **The My dsm-firmenich Benefits Website and Alight Mobile app**—Access your personalized coverage details and manage your benefits throughout the year.
- **Additional support**—If you need help with more complex coverage issues, call **866-300-6530** from 8:00 a.m. to 8:00 p.m. CT, Monday through Friday, and ask to be connected with a Health Pro. Health Pros can explain how benefits work and help resolve

issues. And, expert second opinion with 2nd.MD makes it easy to get a virtual second opinion from nationally recognized doctors.

Preparing for Enrollment

5. How should I prepare for Annual Enrollment?

Annual Enrollment is your opportunity to make benefit changes for the upcoming year. The choices you make during Annual Enrollment are effective January 1 through December 31 of each plan year. You **cannot** add or drop coverage until the next Annual Enrollment unless you experience a qualifying life event, such as a marriage, birth of a child, or change in employment status.

As you prepare to enroll, consider the following questions:

- Which networks do your doctor, dentist, and/or optometrist/ophthalmologist belong to? Choosing a carrier that includes your preferred providers in its network will ensure you pay the least for the cost of service you receive from your providers.
- How will your prescriptions be covered?
- Who do you want to cover and for which plans?
- Are you expecting any elective surgeries or planning to have a baby?
- How much do you want to pay for premiums from your paycheck versus from your pocket at the time you receive care?
- Will you set aside money in the available savings/spending accounts so you can pay health care and dependent care expenses tax-free?
- Did you take full advantage of the plan you chose for 2025 or is there potential to save money in the coming year and have less coverage?

6. What will I need to do during Annual Enrollment?

Be sure to actively enroll through the My dsm-firmenich Benefits website (SSO while on your company network) or the Alight Mobile app between November 17 and December 2, 2025, to secure the coverage you need for next year!

Over the course of the enrollment process, you'll need to:

- Enroll the eligible dependents you want to cover.
- Choose the insurance carriers and coverage levels you want for your medical, dental, and vision benefits.
- Confirm and/or enroll in the rest of your benefits, including your available voluntary options.

You can get information about enrollment on the Make It Yours website at **dsm-firmenich.makeityoursource.com**

7. I was recently hired and enrolled in 2025 benefits. Do I still need to actively enroll again during Annual Enrollment?

You must enroll in order to have coverage effective January 1, 2026. After you were hired, you enrolled in benefits coverage through December 31, 2025.

If you do not take action to re-enroll, you will not have coverage effective January 1, 2026.

To prepare for Annual Enrollment and review your 2026 options, start by visiting the Make It Yours site at **dsm-firmenich.makeityoursource.com**.

8. What happens if I take no action during Annual Enrollment?

If you do not take action and enroll, you will **not** have medical, dental, or vision coverage, supplemental AD&D coverage, supplemental long-term disability coverage, critical illness insurance, hospital indemnity insurance, accident insurance, legal services, or identity theft protection through dsm-firmenich next year.

Keep in mind, if you don't select medical coverage, you won't have prescription drug coverage either.

Additionally, to contribute to a Health Savings Account (HSA) (if eligible) or to a Flexible Spending Account (FSA), you must make an active election.

9. Can I make changes to my elections outside of Annual Enrollment?

The choices you make during Annual Enrollment will be in effect January 1, 2026, through December 31, 2026. You cannot add or drop coverage until the next Annual Enrollment unless you experience a qualifying life event. The following qualifying life events will allow you to make changes to your current benefits during the plan year:

- Marriage
- Divorce or legal separation
- Birth of a child
- Death of your spouse or dependent child
- Adoption or placement for adoption of your child
- Change in employment status of you, your spouse, or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage

10. Do I need to be on the company network to enroll during the Annual Enrollment period?

No. While it is most convenient to enroll while on the company network because you are already "authenticated" (the system knows who you are), you can enroll from any personal computer using the direct URL to the My dsm-firmenich Benefits website (**mydsm-firmenichbenefits.com**) or through the Alight Mobile app. If you use the direct URL or the app, you will need your user ID and password to access your account. If you do not know your user ID and/or password, click the Forgot User ID or Password link on the site and follow the instructions provided.

11. What information should I have available when I enroll during Annual Enrollment?

When you're ready to enroll, make sure to have your eligible dependent(s) date of birth and Social Security number handy. If you add a dependent to your coverage, you will need to submit documentation confirming the eligibility of the dependents you cover in your company's medical/prescription, dental, vision, and life insurance plans. If you add dependents to these plans, you will receive a letter in the mail from the Dependent Verification Center asking you to prove that your dependents meet the eligibility criteria. The letter will include a list of acceptable documents, the submission instructions, and the submission deadline. If you do not comply with this request, and do so by the deadline, your dependents will be dropped from coverage.

When you enroll, you should also be prepared with a list of your (and your family's) preferred providers and the prescription drugs you (and your family) take on a regular basis so you can input them in the **Help Me Choose** tool for personalized coverage recommendations. In order to get the most accurate results, it is recommended that you search for your provider by first and last name—not medical practice.

If you have trouble finding a provider in the tool, or you're uncertain if your preferred providers are part of a carrier's network, call the **insurance carrier** directly for more information.

Enrollment

12. What will I need to do?

Between November 17 and December 2, 2025, you must enroll or you will **not** have medical, dental, or vision coverage, supplemental AD&D coverage, supplemental long-term disability coverage, critical illness insurance, hospital indemnity insurance, accident insurance, legal services, or identity theft protection through dsm-firmenich next year. Keep in mind, if you don't select medical coverage, you won't have prescription drug coverage either. To contribute to a Health Savings Account (HSA) (if eligible) or to a Flexible Spending Account (FSA), you must make an active election.

Note: If you elect supplemental life insurance, your current spouse and child life insurance coverage amounts will continue in 2026.

To enroll, log on to the My dsm-firmenich Benefits website at **mydsm-firmenichbenefits.com** or the Alight Mobile app during the enrollment period. Over the course of the enrollment process, you'll need to:

- Enroll the eligible dependents you want to cover in 2026.
- Choose the insurance carriers and coverage levels you want for your medical, dental, and vision benefits.
- Enroll in the rest of your benefits.

13. How do I create my user ID and password for the My dsm-firmenich Benefits website?

If you are a new user, you will need to set up your user ID and password, which are needed to access your account through the Alight Mobile app (available through the Apple App Store or Google Play).

- Go to the My dsm-firmenich Benefits website and select **New User**;
- Enter the last four digits of your Social Security number and your date of birth to authenticate your account;
- Create your user ID and password; and
- Create answers to security questions to verify your identity if you forget your user ID or password in the future.

14. How do I reset my password for the My dsm-firmenich Benefits website?

To reset your password, go to the My dsm-firmenich Benefits website, click **Forgot User ID or Password?**, and follow the prompts to reset your password. You will need your user ID and password to access your account on the Alight Mobile app (available through the Apple App Store or Google Play).

My Options

15. What are my options for medical and prescription drug coverage?

You have several coverage levels to choose from, including Bronze, Bronze Plus, Silver, Gold, and Platinum. Each coverage level is available from multiple insurance carriers at different costs. When you enroll, you'll be able to compare benefits and features across your medical options.

16. What are my medical carrier options?

In 2026, you'll be able to choose from medical coverage plans offered by national and regional insurance carriers (if available in your area). National carriers include Aetna, Cigna, and UnitedHealthcare. Regional carriers (if available in your area) include Health Net, Dean/Prevea360, Kaiser Permanente, UPMC, Medical Mutual, and Priority Health. Learn about each of the carriers and the areas they serve on the **Make It Yours** website.

17. Does medical coverage differ among insurance carriers?

In general, at each coverage level (Bronze, Bronze Plus, Silver, Gold, and Platinum), carriers have agreed to the majority of standardized plan benefits configured by the benefits marketplace. The My dsm-firmenich Benefits website provides a more detailed look at these and additional coverage details—and does account for some carrier adjustments to standardized plan benefits. To see summaries when you enroll online, check the boxes next to the plans you want to review and click **Compare**. Call the carrier directly to get the most comprehensive information about any specific coverage.

18. How do I decide which medical option is right for me?

You'll have access to a number of resources to help you make smart decisions. You should start by visiting the Make It Yours website at **dsm-firmenich.makeityoursource.com** to access videos, details about your options, comparison charts, and more.

Then, when you enroll, you'll be able to see the credit amount from dsm-firmenich and your price options on the My dsm-firmenich Benefits website at **mydsm-firmenichbenefits.com** or the Alight Mobile app. You'll also be able to access Help Me Choose, a tool that gives you a personalized suggestion based on your preferences, doctors, and any prescriptions you may take.

If you need additional help, once logged on to the My dsm-firmenich Benefits website, look for the "Need Help?" icon to ask your virtual assistant any questions you may have. It can also connect you with a web chat representative and other helpful resources. For additional support, you can schedule an appointment with a customer service representative through the My dsm-firmenich Benefits website. You can also call the dsm-firmenich Benefits Center at **855-dsm-fir0 (855-376-3470)** from 8:00 a.m. to 5:00 p.m. ET, Monday through Friday.

19. Is there a second opinion benefit available with medical coverage?

Yes! All of your company's medical plans will include expert second opinion services on your medical condition through 2nd.MD. 2nd.MD makes it easy to get a virtual second opinion from nationally recognized doctors—available to you at no additional cost if you're enrolled in a company medical plan. You and your family members covered under a company medical plan can connect with board-certified doctors via phone or video.

By connecting with 2nd.MD, you can get an expert second opinion within days for questions like:

- Do I have the correct diagnosis?
- Am I on the best treatment plan?
- Am I taking the right medications?
- Is this surgery or procedure the best option for me?

And you don't need a referral for a second opinion. To get started, visit **2nd.MD/dsmfirmenich** or call **866-841-2575**.

20. What happens if I enroll in a Bronze or Bronze Plus medical option and have expenses shortly after my coverage begins?

If you enroll in a high-deductible medical option, you should be prepared to pay up to the cost of your deductible—in case you have significant medical expenses shortly after your coverage begins. Even if you start contributing to an HSA right away, your HSA may not yet have enough money to cover costly services early in the year. One option is to pay for those early expenses out of pocket and then, when your account balance grows enough to cover the qualified expense, reimburse yourself from your HSA. This is a good reason to make sure you're saving enough in an HSA.

21. I live in California. How are my medical options different?

Your options will be different, depending on the insurance carrier you choose.

For starters, each insurance carrier in California can choose to offer each coverage level either as an option that offers in- and out-of-network benefits (e.g., a PPO) or as an option that offers in-network benefits only (e.g., an HMO).

Also, insurance carriers can choose to offer either the standard Gold option or a Gold II option—not both. The Gold II option only offers in-network benefits.

The Gold option is offered by Aetna, Cigna, and UnitedHealthcare. The Gold II option is offered by Health Net and Kaiser Permanente.

Learn more about your California coverage options and insurance carriers.

22. Will I be able to use the same providers as I do today?

It depends. Each insurance carrier has its own network of preferred providers (e.g., doctors, specialists, hospitals). If you want to keep seeing your current doctors, select an insurance carrier that includes your preferred providers in its network. If you are comfortable changing doctors, select an insurance carrier whose network includes providers critical to your care.

Even if you can keep your current insurance carrier, the provider network could be different and can change, so always check the provider directories before making a decision.

Do not rely on your provider's office to know the carriers' network(s). To see whether your doctor is in the network:

- Check out the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the My dsm-firmenich Benefits website. You can access this information by using the Help Me Choose tool's provider search or clicking **Find Doctors** when you're selecting your medical plan. For the best results:
  - Search for your provider by name—not medical practice.
  - Check the office location(s) you are willing to visit.
  - When searching for a facility, use the complete facility name and confirm whether the specialty of the facility is covered in-network.

Important! If you have any uncertainty (for instance, covering out-of-area dependents) or you need the network name, you need to call the insurance carrier.

23. Why should I use in-network providers?

Seeing out-of-network providers will cost you substantially more than seeing in-network providers. For example, you will pay more through a higher deductible and higher coinsurance. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum allowed amount, even after you've reached your annual out-of-network out-of-pocket maximum. And certain options/carriers in California won't cover out-of-network services at all.

24. How should I choose a medical insurance carrier if my dependents and I live in different states?

Because you and your dependents must enroll in the same option, you may want to consider one of the national insurance carriers that offer national provider networks so that your dependents have access to in-network providers in most locations. (Regional insurance carriers *may* offer in-network coverage outside of their regional service area through partnerships with other carriers. You can contact the insurance carrier for details.)

Do not rely on your provider's office to know the carriers' network(s). You need to call the insurance carrier to confirm whether an out-of-area provider participates in a carrier's network.

25. How can I find the medical option that's most similar to the one I have today?

That's a good question. You may currently have medical insurance with a carrier who is also an option for you next year. This is not the same plan, and the provider networks are different from what you could have today. You need to take a close look at the coverage options and carrier networks to decide which will meet your needs best.

When you enroll, you'll also be able to access Help Me Choose, a tool that gives you a personalized suggestion based on your preferences, doctors, and any prescriptions you may take. It will be easy to compare your options on the My dsm-firmenich Benefits website because you'll be able to sort them by the features that are most important to you. You can also call the insurance carriers with specific questions about the options they offer.

26. Will pre-existing conditions be covered?

Yes. When you enroll in medical coverage through dsm-firmenich, coverage is guaranteed, regardless of whether you and/or your eligible dependents have pre-existing conditions.

27. How will my prescription drugs be covered?

Your prescription drug coverage will be provided through your pharmacy benefit manager—which could be a separate prescription drug company. Each pharmacy benefit manager has its own rules about how prescription drugs are covered. That's why you need to do your homework to determine how your medications will be covered before choosing an insurance carrier.

If you or a covered family member regularly takes medication, it is strongly recommended that you call the medical insurance carrier before you enroll to better understand how your particular prescription drug(s) will be covered. Do not assume that your generic or brand name medication will be covered the same way by each carrier each year. Visit the Make It Yours website for a list of questions to ask. When you enroll, you can use the prescription drug search tool to look up your medication and see how it will be covered.

28. What is "prior review" or "prior authorization" and when is it required?

Before getting certain types of care, you and your doctor may be required to run it by your insurance carrier first. Getting "prior review" (also referred to as prior authorization or precertification) allows the carrier to make sure you're eligible for the services, ensure you're getting care that makes sense for your condition, and confirm how the bill is going to be paid.

Who completes the process depends on where you get care:

- When you stay in network, your doctor usually completes the process on your behalf when it's required. Always confirm with your doctor to be sure they are handling it.
- If you go out of network, you are usually responsible for completing the process. You may have to work with your doctor or directly with your insurance carrier to fill out paperwork and receive the appropriate approval before getting care.

When prior review is required and you don't get preapproved, you could get stuck paying most or all of the bill or a penalty. For that reason, it's always in your best interest to ask your doctor whether you need to do anything in advance and confirm that services you need will be covered by your insurance carrier.

29. Will I receive a new ID card for medical and prescription drug coverage?

Depending on your carrier, you'll receive either a physical ID card in the mail or an electronic ID card via the carrier's member site or mobile app after you enroll for the first time. Electronic ID cards can be downloaded and saved to your e-wallet. You'll use your ID card for medical and prescription drug needs.

You should receive ID cards before your benefits take effect. If you need an ID card immediately, go to your insurance carrier's website, register online, and download or print a temporary ID card.

30. What do I need to know about dental networks?

Just like the medical insurance carriers, each dental carrier has its own provider networks that can vary by the coverage level you choose. If it's important that you continue using the same dentist, you should check to see whether your dentist is in the network before you choose a carrier.

Do not rely on your provider's office to know the carriers' networks. To see whether your dentist is in the network:

- Check out the insurance carrier preview sites.
- When you enroll, check the networks of each insurance carrier you're considering on the My dsm-firmenich Benefits website.

If you are considering a Platinum dental option:

- It may cost less than some of the other options, but you **must** get care from a dentist who participates in the insurance carrier's DHMO network. The network could be considerably smaller, so be sure to check the availability of local in-network dentists **before** you enroll.
- The Platinum dental option does **not** provide out-of-network benefits. So if you don't use a network dentist, you'll pay for the full cost of services.

31. How does orthodontia treatment in progress work?

For orthodontia treatment in progress, carriers will obtain and apply amounts already accumulated towards the lifetime maximum, even if the prior carrier is a non-exchange carrier. This is the industry standard and is adhered to by all dental carriers.

For example, if a participant began orthodontia treatment in March of 2025, then elects a new carrier through your benefits marketplace and continues treatment in the new plan year, once the next claim is submitted on their behalf, the new carrier will reach out to that service provider to obtain information on treatment and cost remaining. The carrier will then use this information to review the claims, determine where they are in treatment and pro-rate the remaining amount of coverage. If the plan determines that $800 of coverage was received in 2025, the new carrier will cover $700 of coverage in 2026, assuming a $1,500 lifetime maximum.

32. What do I need to know about vision networks?

Each vision insurance carrier has its own provider network. If it's important that you continue using the same eye doctor or retail store, you should check to see whether your eye doctor or retail store is in the network before you choose a carrier.

Do not rely on your provider's office to know the carriers' networks. To see whether your eye doctor or retail store is in the network:

- Check out the insurance carrier review sites.
- When you enroll, check the network of each insurance carrier you're considering on the My dsm-firmenich Benefits website.

33. Is the company still offering a wellness program and incentive?

Yes, invest in your physical and emotional health with activities and challenges that support your personal goals, all while earning rewards through Personify Health.

All employees will be eligible for $400 in annual rewards and enrolled spouses are eligible for $100 in annual rewards.

Additionally, in partnership with Personify, we offer RethinkCare. RethinkCare is the leading global behavioral and mental health platform supporting neurodiversity in the workplace and at home. We offer a digital experience and on-demand clinical consulting to empower employees across their parenting, professional, and personal needs.

34. What other benefit options are available to me?

You can choose to supplement your medical coverage with:

- **Critical illness insurance:** Pays a benefit if you or a covered family member is treated for a major medical event (such as a heart attack or stroke) or diagnosed with a critical illness (such as cancer or end-stage kidney disease).
- **Hospital indemnity insurance:** Pays a benefit in the event you or a covered family member is hospitalized.
- **Accident insurance:** Pays a benefit in the event you or a covered family member is in an accident.

You can also choose to enroll in:

- **Supplemental life insurance:** Protects your family financially in the event of a death. In order to elect spouse/child life insurance, you must elect supplemental life insurance for yourself.
- **Supplemental accidental death and dismemberment (AD&D) coverage:** Protects your family financially in the event of a tragic accident.
- **Supplemental long-term disability coverage:** Provides you with income if you are unable to work due to an illness or non-work-related injury.
- **Legal services:** Covers attorney fees for things like wills, real estate matters, and more.
- **Identity theft protection:** Monitors your personal information and takes steps to protect you from fraud.

You can get more details on the Make It Yours website at **dsm-firmenich.makeityoursource.com**.

35. What else is available to me?

We are able to take advantage of group negotiated discounts for:

- **Auto and home insurance:** Offers you special group rates and policy discounts on auto and home insurance.
- **Pet insurance:** Helps pay veterinary expenses for your sick or injured dog or cat.

You also have access to other services:

- **Expert second opinion with 2nd.MD:** Makes it easy to get a virtual second opinion from nationally recognized doctors. To get started, simply visit **2nd.MD/dsm-firmenich** or call **866-887-0712**.

You can get more details on the Make It Yours website at **dsm-firmenich.makeityoursource.com**.

36. Who is our employee assistance program (EAP) provider?

Our employee assistance program (EAP), is provided through Magellan Healthcare and provides confidential counseling to you or your family and household members who are dealing with:

- Bereavement
- Legal questions or concerns
- Marital or family conflicts
- Childcare and senior care
- Financial problems
- Alcohol/drug issues
- Work-related issues
- Stress/emotional issues

You can receive support from counselors in-person, by text message, live chat, phone, or video conference, as well as referrals for in-person consultations with clinical, legal, and financial professionals. Contact Magellan at **Magellan Healthcare** or call **1.800.523.5668**.

37. Are there additional support services available?

RethinkCare is the leading global behavioral and mental health platform supporting neurodiversity in the workplace and at home. We offer a digital experience and on-demand clinical consulting to empower employees across their parenting, professional, and personal needs. Learn more at **RethinkCare.com**.

38. Do I have to verify eligibility of my dependent(s) to be covered on my company benefits?

It depends. If your dependents (including domestic partner) were previously verified and enrolled, you do **not** need to verify their eligibility. If you are adding new dependents to your benefits who were not previously enrolled and verified, you will need to verify their eligibility.

When you add a new dependent, the My dsm-firmenich Benefits Center will send a request to your home address requiring certain verification documentation; there will be an expressed deadline within this communication. Responding and sending documentation is mandatory. If you do not respond by the deadline, your dependent(s) will be removed from coverage and will not be eligible for COBRA coverage. Individuals found to be ineligible for coverage under the company's plans will be dropped from coverage as well.

Paying for Coverage

39. Will I have to pay more for medical coverage?

It depends. You can choose the coverage level you want from the insurance carrier offering it at the best price. There are other factors that impact how much you pay too, including your credit amount from dsm-firmenich and how many family members you cover. The result is that you could end up paying more—or less—for coverage than you do today.

Keep in mind, you'll pay the cost of medical (and dental and vision) coverage with before-tax dollars.

40. When will I find out the cost of the various insurance coverage options?

We understand that you may be eager to know the pricing now. The pricing structure is tailored to your regional area and your specific coverage needs. Because it is customized, you will be able to access your specific pricing information through the My dsm-firmenich Benefits website at **mydsm-firmenichbenefits.com** or the Alight Mobile app during the enrollment window.

41. Do I get to keep the dsm-firmenich credit if I don't enroll in coverage?

No. The credit you get from dsm-firmenich is for the medical/prescription drug, dental, and vision coverage you purchase. A cash refund or credit for other benefits is not available. Exception: If you enroll in a Bronze or Bronze Plus coverage level and don't use the full credit, the unused dollars will be deposited into your HSA.

42. Are there additional costs I need to be aware of?

If you, your spouse/domestic partner, or your dependent child(ren) are a tobacco user and enrolled in a dsm-firmenich plan, a $600 annual surcharge per user will apply and be deducted from your paycheck, along with your other benefit deductions.

A tobacco user is defined as any use of tobacco products, regardless of the frequency within the past six months. Tobacco products include cigarettes, e-cigarettes, cigars, pipes, vaping, bidis, hookah, cloves, snuff, and smokeless tobacco (i.e., dip, chewing tobacco).

43. What's a deductible and how does it work?

The deductible is what you pay out of your own pocket before your insurance carrier begins to pay a share of your costs. If you have a deductible, you pay the full "negotiated" costs of all in-network services until you meet your deductible. The "negotiated" costs are the payments providers (doctors, hospitals, labs, etc.) have agreed to accept from the insurance carrier for providing a particular service.

How the medical deductible works depends on your coverage level:

- **The Bronze, Silver, Gold, and Platinum medical coverage levels have a traditional deductible.** Once a covered family member meets the *individual* deductible, your insurance will begin paying benefits for that family member. Charges for all other covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.
- **The Bronze Plus has a "true family deductible."**[1] This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members. There is no "individual deductible" in these coverage levels when you have family coverage.

To clarify, if you choose a Bronze Plus coverage level, the individual deductible only applies if you cover just yourself. If you choose to cover dependents too, though, you must satisfy the family deductible before coinsurance will kick in, even if only one family member has expenses.

The annual deductible doesn't include copays or amounts taken out of your paycheck for health coverage.

Do you use out-of-network providers? Out-of-network charges do not count toward your in-network annual deductible; they only count toward your out-of-network deductible.

[1]Exception: If you live in California, cover dependents, and enroll under Health Net or Kaiser Permanente at the Bronze Plus coverage level, you will have a *traditional* annual deductible.

44. What's an out-of-pocket maximum and how does it work?

The annual out-of-pocket maximum is the most you and your covered family members would have to pay in a year for health care costs. The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage. How the medical out-of-pocket maximum works depends on your coverage level.

The Bronze, Silver, Gold, and Platinum coverage levels have a traditional out-of-pocket maximum. Once a covered family member meets the *individual* out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member. Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.

The Bronze Plus coverage levels have a "true family out-of-pocket maximum."[2] This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member. There is no "individual out-of-pocket maximum" in these options when you have family coverage.

Do you use out-of-network providers? Out-of-network charges do not count toward your in-network annual out-of-pocket maximum; they only count toward your out-of-network out-of-pocket maximum.

[2]Exception: If you live in California, cover dependents, and enroll under Health Net or Kaiser Permanente at the Bronze Plus coverage level, you will have a *traditional* annual out-of-pocket maximum.

45. What's a Health Savings Account (HSA)?

An HSA is a special bank account that you can use when you enroll in a Bronze or Bronze Plus coverage level. It allows you to set aside tax-free money to pay for qualified health care expenses, like your medical, dental, and vision copays, deductibles, and coinsurance. Because you'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze or Bronze Plus (with exceptions in California) coverage levels, an HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Just make sure you use money in your HSA only for qualified health care expenses. If you use money in your HSA for unqualified expenses, you'll pay income taxes on that money and an additional 20% penalty tax if you're under age 65. Keep careful records of your health care expenses and withdrawals from your HSA, in case you ever need to provide proof that your expenses were qualified.

You can decide whether to enroll in an HSA and how much (if any) money you want to contribute. If you don't have a lot of health care expenses, your money can stay in your account year to year and earn tax-free interest. Also, the money is yours to keep even after you no longer work for the company. If you have questions about the use and appropriateness of an HSA as it applies to your specific situation, you should consult a tax professional.

46. Why would I want to use an HSA?

An HSA lets you set aside money to pay for qualified health care expenses, like your medical, dental, and vision copays, deductibles, and coinsurance. You decide how much money you want to contribute, and you can change your contribution election at any time. If you don't have a lot of health care expenses, your money can stay in your account year to year.

The HSA has the following tax advantages:

- Your contributions to an HSA are tax-free, meaning that they are deducted from your paycheck before taxes are taken out.
- Interest earnings on your HSA balance are not taxed.
- You are not taxed on the HSA dollars when you use them to pay qualified expenses.

47. How is an HSA different from a Health Care Flexible Spending Account (Health Care FSA)?

While both accounts offer a tax-free benefit when you pay for eligible medical, dental, and vision expenses, they differ in several key ways. Compare their differences on the Make It Yours website.

48. Can I enroll in both an HSA and a Health Care FSA?

Yes. If you enroll in the Bronze or Bronze Plus (with exceptions in California) coverage level, you can use an HSA, a Health Care FSA, or both an HSA and a Limited Purpose Health Care FSA. If you have an HSA and a Health Care FSA, in order to contribute to an HSA, your FSA will be "limited purpose" and can only be used to pay for qualified dental and vision expenses. However, once you meet the medical deductible, then it can be used toward eligible medical and prescription drug expenses as well. Your HSA can be used for eligible medical and prescription drug, dental, and vision expenses.

49. Why would I want to use both an HSA and a Limited Purpose Health Care FSA?

Both accounts allow you to pay for eligible expenses with tax-free dollars. The biggest difference between the accounts is that your HSA balance rolls over from year to year, even if you change medical plans, leave the company, or retire. With the Health Care FSA (whether limited purpose or not), any unused balance exceeding $660 is forfeited at the end of the year.

It may not be advantageous to enroll in both, except in unique situations. For example, if you expect to have higher expenses than your HSA balance can cover (based on the maximum you can contribute each year), you may also want to contribute to the Limited Purpose Health Care FSA to pay for those expenses with tax-free money once the medical deductible is reached.

50. Can I contribute to an HSA if I am covered under my spouse's general purpose Health Care FSA?

No. If your spouse's general purpose Health Care FSA covers your medical expenses, it would be considered other health coverage and you would not be eligible to contribute to an HSA.

51. Can I contribute to an HSA?

In order to contribute to an HSA, you need to meet the following criteria:

- You must be enrolled in a high-deductible option at the Bronze or Bronze Plus coverage level;
- You cannot be enrolled in Medicare or a veteran's medical plan (TRICARE);
- You cannot be claimed as a dependent on someone else's tax return;
- You cannot be covered by any other health insurance plan, such as a spouse's plan, that is not a high-deductible option; and

- You cannot be enrolled in a general purpose Health Care FSA, but you may be enrolled only in a Limited Purpose Health Care FSA.

You can use money from your HSA to pay your dependents' health care expenses as long as you claim them as dependents on your federal income taxes (generally children up to age 19 or under age 24 if they are full-time students).

52. Will my HSA administrator change?

Yes. The HSAs offered through dsm-firmenich will be administered by Alight Smart-Choice Accounts. If you already have an HSA with an account balance, you will have the option to transfer unspent money to Alight Smart-Choice Accounts by completing a form and following its instructions.

53. Will I receive a company contribution into my HSA?

It depends. If enrolling in a Bronze or Bronze Plus plan, the company credit may exceed the total cost of coverage. Any excess credit will be contributed to your HSA. The maximum company credit to the HSA is $1,200 for employee only coverage and $2,400 for all other coverage tiers. Company credits to the HSA will be made by the 5th day of the month for the preceding month's credit allowances (for example, January credits will be funded and available to you on February 5).

54. What is a Dependent Care FSA (DCFSA) and why would I want to enroll in one?

The DCFSA is an account that helps you save and pay for qualified child (under age 13) and dependent care expenses, such as child day care. Dependent health care expenses do **not** qualify under a DCFSA. Contributions to the account are pre-tax through payroll deduction. Thus, you don't incur tax when you are reimbursed from your account, and your year-end taxable income is lower. You determine the annual dollar amount to contribute when you enroll, up to maximum IRS limits.

Unlike an HSA, money in an FSA is "use it or lose it" each year, so it's important that you carefully estimate your anticipated eligible expenses for the coming year.

You do **not** need to be enrolled in medical coverage to enroll in the DCFSA.

If you're parenting a young child or caring for an elderly parent, you can use the DCFSA to pay for preschool, summer camp, before- and after-school programs, and child or elder day care. For other eligible expenses, visit **irs.gov/pub/irs-pdf/p503.pdf**.