Evonik Corporation Dental Plan
Summary Plan Description (SPD)

SUMMARY PLAN DESCRIPTION
FOR
ELIGIBLE EMPLOYEES AND LTD PARTICIPANTS AND CERTAIN RETIREES
(AND THEIR ELIGIBLE DEPENDENTS)
IN THE EVONIK CORPORATION DENTAL PLAN
EFFECTIVE JANUARY 1, 2021

This document is the Summary Plan Description (SPD) for the Evonik Corporation Plan Dental (the Plan) for non-union and certain union Employees of Evonik Corporation and former Employees receiving benefits under the Evonik Long Term Disability Program and certain pre-65 and Post Retirees who meet certain age and service requirements (described in the Base Retiree SPD) (together "Covered Persons"). This SPD outlines the rights and benefits of Covered Persons and their Dependents and describes the major provisions of the Plan as in effect on January 1, 2021. This booklet, together with either the Evonik Active and LTD Base SPD or the Retiree Base SPD will constitute the entire SPD for the dental options. Eligibility for the dental options, as well as important legal information is located in the either the Evonik Active and LTD Base SPD or Retiree Base SPD. The dental options benefit details are in this booklet.

The Plan is a participating Plan under the Evonik Corporation Consolidated Welfare Benefits Program (the Program), sponsored by Evonik Corporation (the Company), if you are an Employee or are receiving benefits under the Evonik Long Term Disability Program. The Plan also is a participating Plan under the Evonik Corporation Consolidated Retiree Welfare Benefits Program (the Program) if you are an eligible Retiree. The Plan provides dental benefits to eligible Covered Persons of the Company and its participating Employer affiliates. You may check with Mercer Marketplace to verify that your employer is a participating Employer at 1-855-684-6628, Monday through Friday, 7:00 am to 9:00 pm, ET.

This SPD is intended to explain the terms of the Plan in non-technical, everyday language, but capitalized terms and phrases have specific meanings within the context of the Plan. These special capitalized terms are defined in the *Defined Terms* section at the end of this SPD.

The complete terms and conditions of the Plan are described in a complex legal Program document. Plan benefits are paid only if provided for in the official Program document. If there are any differences between this SPD and the official Program document, the Program document will govern.

Benefits under the fully insured option (Delta Dental of PA) for Covered Persons who are Oil Additives employees in the Horsham or Deer Park locations are described in detail in the certificate of coverage issued by the provider. If you elect coverage under the fully insured dental option, the certificate of coverage is incorporated into and is part

of this SPD. In the event of a conflict between the certificate of coverage and the terms described in this document, the certificate of coverage will govern except as specifically noted in this document.

Note: Covered Persons who are Oil Additives employees in the Horsham or Deer Park locations who are enrolled in the Delta Dental PA coverage option will receive a certificate of coverage directly from Delta Dental PA. Please review that certificate of coverage in addition to this document. The certificate of coverage contains details of coverage levels and costs under the Delta Dental PA coverage option.

The terms “you” and “your” as used in this Summary Plan Description refer to Covered Persons of the Company or a participating Employer who meets all the eligibility and participation requirements under the Plan (and, with respect to certain benefits rights and participant obligations under the Plan, the eligible Covered Person covered Dependents. Receipt of this SPD does not guarantee that the recipient is a Covered Person under the Plan and/or otherwise eligible for benefits under the Plan.

Introduction

Participation in the Plan will take effect once you enroll in accordance with the Company’s procedures. Enrollment is not automatic. If you are an active employee and you do not enroll when initially eligible, you must wait until the next annual enrollment to participate in the Plan unless you have a change in status or other event permitting you to make a mid-year election change. Retirees and LTD Participants who do not enroll when initially eligible cannot enroll during the next annual enrollment period or elect to enroll in coverage if you have a qualifying status change. These Election Changes During the Year may be found in the Active and LTD Base SPD and the Retiree Base SPD. The Plan provides benefits only for the expenses incurred by Covered Persons while the Plan is in effect. No benefits are payable for expenses incurred before the Plan began or after the Plan is terminated. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

All benefits described in this SPD are subject to the exclusions and limitations in this Plan including, but not limited to, the Claims Administrator's determination that care and treatment is necessary according to generally accepted medical standards of care as defined by the Claims Administrator.

The coverage and benefit levels described in this document are subject to change. Please contact the Mercer Service to confirm cost and coverage information. Benefits under this Plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them.

Important Information About the Plan

The Plan is a dental plan which is a “welfare benefit plan” under Section 3(1) of the Employee Retirement Income Security Act of 1974. There are six coverage options offered under the Plan, some of which are available only to individuals living in certain geographic areas. The Aetna DPO, Aetna DMO®, Blue Cross Blue Shield of AL, MetLife Basic Core and MetLife Premium options are self-funded through the Company’s general assets. The funding for the benefits under these self-funded dental options is derived from the general funds of the Company and any contributions made by Covered Persons.

The Delta Dental of PA option is fully-insured. The benefits payable under the Delta Dental of PA plan is provided through contracts issued by the provider. The provider is responsible for determining the premiums and paying claims under the terms of the insurance contract. The Company pays the required premiums to the provider with amounts from the Company’s general funds and the required contributions made by Covered Persons.

The Plan is administered by third party Claims Administrators on behalf of the Plan Administrator. For the fully-insured Delta Dental of PA, the Claims Administrator is the provider.

General Plan Information

Dental Option

Aetna DPO and Aetna Dental Maintenance Organization® (DMO®)

- Group Number:
  - 12//31/2021 and prior #820377
  - 01/01/2022 # 175064
- Customer Service: 877-238-6200
- Website: www.aetna.com
- Claim Address:
  Aetna Dental
  P.O. Box 14094
  Lexington, KY 40512

BCBS of AL

- Group Number: 00064
- Customer Service: 833-994-0014
- Website: www.alabamablue.com
- Claim Address:
  Blue Cross and Blue Shield of Alabama
  P.O. Box 995
  Birmingham, AL 35298

Delta Dental of PA

- Group Number: 02467
- Customer Service: 800-932-0783
- Website: www.deltadentalins.com
- Claim Address:
  Delta Dental of PA
  One Delta Drive
  Mechanicsburg, PA 17055

MetLife

- Group Number: 307304
- Customer Service:
  - Customer Service: 800-942-0854
  - Provider Directories: 800-474-7371
- Website: www.metlife.com/dental
- Claim Address:
  Metropolitan Life Company
  Dental Claims
  P.O. Box 14093
  Lexington, KY 40512-4093

The coverage and benefit levels described in this document are subject to change. Please contact the Plan Administrator to confirm cost and coverage information. Benefits under this Plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them.

PLAN COVERAGE OPTIONS

The Dental Plan provides comprehensive coverage for many dental procedures and is offered to help Covered Persons pay for dental care. The Dental Plan offers the following choice of dental options depending on your home zip code:

- Aetna DPO (available in all locations) – offered to Active employees, LTD Participants, Oil Additives Pre-65 Retirees who retired prior to 1/1/17 and Stockhausen, LA Pre and Post 65 Retirees who retired prior to April 26, 2006.
- Aetna DMO (based on zip code – offered only to Active and LTD Participants)
- Blue Cross and Blue Shield of Alabama PPO (available in certain states – see below) – offered to Active employees, LTD participants and Stockhausen, LA Pre 65 and Post 65 Retirees who retired on or before April 26, 2006.
- Delta Dental of PA PPO* (only offered to Oil Additives Active Employees, LTD Beneficiaries and Oil Additives Pre 65 retirees whose location is in Horsham or Deer Park)
- MetLife Basic Plan (offered only to Active Employees and LTD Participants)
- MetLife Premium Plan (offered only to Active Employees and LTD Participants)

***Note: The Blue Cross Blue Shield of Alabama options are only offered to Employees, LTD Participant, Stockhausen, LA retirees who retired prior to 4/26/06 whose business unit is located in the states of Alabama, Arkansas, Georgia, Florida, Illinois, Louisiana, Michigan, Mississippi, and North Carolina.**

IMPORTANT: Orthodontic Expenses under the Aetna Health Care Flexible Spending Account under the Evonik Corporation Flexible Benefit and Spending Account Plan For Active Employees - Reimbursement for orthodontic expenses under the Aetna Health Care Flexible Spending Account can only be reimbursed as services are incurred. Approximately one third of the total cost can be reimbursed up front, as it can be attributed to the molds, application of appliances, etc. After that, reimbursement can be made in monthly payments, throughout the duration of the treatment plan as services are incurred.

AETNA DENTAL COVERAGE OPTIONS

This section applies only to the two Aetna dental coverage options offered under the Plan:

- Aetna DPO
- Aetna DMO

AETNA DPO DENTAL OPTION

This section applies only to the Aetna DPO dental coverage option offered under the Plan.

The Aetna DPO allows you the flexibility to choose a participating Preferred Care Provider Dentist (in-network) or a non-Preferred Care Provider Dentist (out-of-network) each time you need dental services. Preferred Care Providers agree to provide services to Covered Persons at a reduced fee (Negotiated Charge). Therefore, you can receive benefits at a lower cost under the Plan by using a Preferred Care Provider. In order to maximize benefits, you should obtain dental care from a Preferred Care Provider. Another advantage of using Preferred Care Providers is that there are no claim forms to submit. Your Preferred Care Provider will submit a claim to the Claims Administrator for payment and then bill you directly for any Coinsurance that you must pay. If you use a Dentist who is not a Preferred Care Provider, on the other hand, you will need to pay the Dentist and then submit a Claim for reimbursement. You are responsible for any charges above the Reasonable and Customary reimbursement,

The covered services are the same regardless of whether you use a Preferred Care Provider or a non-Preferred Care Provider. However, when you obtain care from a Preferred Care Provider, your out of pocket expenses will be lower than when you use a non-Preferred Care Provider.

In order to locate a Preferred Care Provider, you should consult the Directory of Preferred Care Providers and select a Preferred Care Provider near you for the type of services you need. Contact the Aetna Member Services to request a free copy of the Preferred Care Provider Directory or for assistance with finding a Preferred Care Provider. You can also find this information at the Aetna website: www.aetna.com.

Below are the highlights of the Aetna DPO dental coverage option.

AETNA DENTAL DPO COVERAGE OPTION

AETNA DPO DENTAL OPTION Summary of Coverage		
Features	**In-Network**	**Out-of-Network**
Deductible (per Plan Year) • Individual • Family (maximum of 3 Deductibles per family)	 $ 50 $150	 $ 50 $150
Annual Benefit Maximum (per Plan Year) • Per Individual (applies to Preventive, Basic and Major Services)	$1,500	$1,500
Lifetime Maximum for Orthodontics • Per Individual	$1,500	$1,500
Preventive Services • Oral examinations (twice a Plan Year) • Cleanings, including polishing (twice a Plan Year) • Fluoride (one course of treatment per year for children up to age 18) • Sealants (one application every 3 years for permanent molars only, for children under age 15) • Bitewing X-rays (twice a Plan Year) • Full Mouth series X-rays (limited to one set each 36 months) • Space Maintainers – Fixed and removable unilateral or bilateral (adjustments within 6 months after installation)	100% of Negotiated Charge	100% of Usual and Reasonable Charge
Basic Services • Root canal therapy (anterior/bicuspid teeth) • Amalgam (silver) fillings • Composite fillings (anterior teeth only) • Scaling and root planing • Periodontal maintenance • Uncomplicated extractions • Surgical removal of erupted tooth • Surgical removal of impacted tooth (soft tissue)	80% of Negotiated Charge after Deductible	80% of Usual and Reasonable Charge after Deductible

AETNA DENTAL DPO COVERAGE OPTION

AETNA DPO DENTAL OPTION Summary of Coverage		
Features	**In-Network**	**Out-of-Network**
Major Services • Molar root canal therapy • Osseous surgery • General anesthesia/intravenous sedation • Inlays, onlays or crowns • Full & partial dentures • Denture repairs • Dental Implants • Oral surgery (except impacted wisdom teeth) Note: Surgical removal of impacted wisdom teeth is not covered under the Aetna DPO dental coverage option. Oral Surgery for surgical removal of impacted wisdom teeth is considered a covered medical expense under the Evonik Medical Plan.	50% of Negotiated Charge after Deductible	50% of Usual and Reasonable Charge after Deductible
Orthodontic Services (Adult and Children)	50% of Negotiated Charge up to a separate $1,500 orthodontic Lifetime maximum	50% of Usual and Reasonable Charge up to a separate $1,500 orthodontic Lifetime maximum

AETNA DENTAL DPO COVERAGE OPTION

EXPLANATION OF BENEFITS

Annual Maximum Benefit. There is a per individual annual maximum benefit per Plan `Year of $1,500 for preventive, basic and major services. Once an individual has reached the $1,500 annual maximum benefit, no additional benefits will be paid for that individual under the Plan for that Plan Year. Benefits paid for orthodontia do not count toward the annual maximum benefit. There is a separate annual maximum benefit for in-network care and out-of-network care.

Lifetime Maximum for Orthodontic Services. There is a separate $1,500 orthodontia Lifetime benefit maximum per individual. Once the per individual Lifetime benefit maximum has been reached for orthodontic services, no additional orthodontic benefits will be paid for that individual under the Plan. Benefits will be subject to any applicable benefit limits. Benefits paid for orthodontia do not count toward the annual maximum benefit.

Annual Individual Deductible. Your annual per Plan Year Deductible is the amount you must pay before most benefits are paid by the Plan. Preventive care benefits are not subject to the Deductible; the Plan will cover your preventive care Covered Dental Expenses even if you have not yet reached your Deductible for the Calendar Year. There is a separate deductible for in-network care and out-of-network care.

Annual Family Deductible. The individual annual Plan Year Deductible applies to all Covered Persons. If you have family coverage, then all Covered Persons in your family are considered to have satisfied the individual Deductible once the family Deductible is satisfied. The family Deductible is the total amount you must pay for Covered Dental Expenses for Covered Persons in your family each Plan Year before most benefits are paid by the Plan for Covered Persons who have not independently satisfied the individual Deductible. In other words, once Covered Dental Expenses incurred in a Calendar Year by you and your covered Dependents equal the family Deductible limit, you and all of your covered Dependents will be deemed to have met the individual Deductible limit for the rest of that Calendar Year. Preventive care benefits are not subject to the Deductible; the Plan will cover your preventive care Covered Dental Expenses even if you have not yet reached your Deductible for the Calendar Year. There is a separate deductible for in-network care and out-of-network care.

Advance Claim Review

Before starting a course of treatment for which Dentists' charges are expected to be $250 or more, details of the proposed course of treatment and charges should be sent to the Claims Administrator in advance of the treatment (called "Advance Claim Review"). The Claims Administrator will then estimate your benefits. You and the Dentist will be advised on what the estimated benefits are before treatment begins. Advance Claim Review is recommended but is not required. Advance Claim Review is intended to prevent you from incurring large, unexpected out-of-pocket dental expenses.

AETNA DENTAL DPO COVERAGE OPTION

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending Dentist as a result of an oral exam. The treatment may be given by one or more Dentists. The course of treatment starts on the date a Dentist first gives a service to correct or treat such dental condition.

As a part of Advanced Claim Review and as part of proof of any claims:

- The Claims Administrator has the right to require an oral exam of the Covered Person. This will be done at no cost to the Covered Person.
- A Covered Person must give the Claims Administrator all diagnostic and evaluative material which it may require. These include X-rays, models, charts and written reports.

The benefits for a course of treatment may be for a lesser amount than would otherwise be paid if any required verifying material is not furnished. In this event, benefits will be reduced by the amount of dental expenses that the Claims Administrator cannot verify.

Alternate Treatment Rule

If more than one service can be used to treat a Covered Person's dental condition, the Claims Administrator may decide to authorize coverage only for a less costly covered service provided that both of the following terms are met:

- The service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- The service selected must meet broadly accepted national standards of dental practice.

Replacement Rule

The replacement of, addition to, or modification of existing dentures, casts or processed restorations, removable denture, fixed bridgework, implants or other prosthetic services, is covered only if *one* of the following terms is met.

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the Covered Person when the extraction took place.
- The existing denture, cast, or processed restoration, removable denture, bridgework, implant or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.
- The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

AETNA DENTAL DPO COVERAGE OPTION

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures, fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures, fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this Plan coverage was in force for the Covered Person; and (ii) are not abutments to a partial denture, removable bridge, or fixed bridge installed during the prior 5 years.

Impacted Wisdom Teeth

Surgical removal of impacted wisdom teeth is not covered under the Aetna DPO dental coverage option. Oral Surgery for surgical removal of impacted wisdom teeth is considered a covered medical expense under the Evonik Medical Plan.

AETNA DENTAL DPO COVERAGE OPTION

AETNA DPO DENTAL OPTION
COVERED DENTAL EXPENSES

The following is a list of Covered Dental Expenses under the Aetna DPO dental coverage option. All services are subject to the Plan's maximum annual benefit, age and frequency limits. Refer to the *General Exclusion* section for information on dental expenses that are not covered under the Plan.

Preventive Services. The Plan will pay 100% of a Preferred Care Provider's Negotiated Charges. When you use a non-Preferred Care Provider, the Plan will cover 100% of the Dentist's Usual and Reasonable Charge. Please note that the Dentist's actual charge may be greater than the Usual and Reasonable Charge, in which case the Covered Person must pay the difference. Below is a list of Covered Dental Expenses for preventive care services:

- Oral examinations (twice a Plan Year)
- Cleanings, including polishing (twice a Plan Year)
- Fluoride (one course of treatment per year for children under age 18)
- Sealants per tooth (one application every 3 years for permanent molars only children under age 15)
- Bitewing X-rays (twice a Plan Year)
- Full Mouth series X-rays, including bitewing, if necessary, or panoramic film (limited to one set each 36 months)
- Space Maintainers – Fixed and removable unilateral or bilateral (adjustments within 6 months after installation)

Basic Services. The Plan will reimburse up to 80% a Preferred Care Provider's Negotiated Charges after the Deductible has been met or reimburse 80% of the Dentist's Usual and Reasonable Charge after the Deductible has been met for a non-Preferred Care Provider. Please note that the Dentist's actual charge may be greater than the Usual and Reasonable Charge, in which case the Covered Person must pay the difference. Below is a list of Covered Dental Expenses for basic services.

- Root canal therapy (anterior/bicuspid teeth)
- Amalgam (silver) fillings
- Composite fillings (anterior teeth only)
- Scaling and root planing
- Periodontal maintenance
- Uncomplicated extractions
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissue)

AETNA DPO DENTAL OPTION
COVERED DENTAL EXPENSES

Major Services. The Plan will reimburse up to 50% of a Preferred Care Provider's Negotiated Charges after the Deductible has been met or reimburse 50% of the Dentist's Usual and Reasonable Charge after the Deductible has been met for a non-Preferred Care Provider. Please note that the Dentist's actual charge may be greater than the Usual and Reasonable Charge, in which case the Covered Person must pay the difference. Below is a list of Covered Dental Expenses for major services:

- Molar root canal therapy
- Osseous surgery
- General anesthesia/intravenous sedation
- Inlays, onlays or crowns
- Full & partial dentures
- Denture repairs
- Dental Implants
- Oral surgery (except impacted wisdom teeth)

Note: Surgical removal of impacted wisdom teeth is not covered under the Aetna DPO dental coverage option. Oral Surgery for surgical removal of impacted wisdom teeth is considered a covered medical expense under the Evonik Corporation Medical Plan.

Orthodontic Services. The Plan will reimburse up to 50% of a Preferred Care Provider's Negotiated Charges after the Deductible has been met or reimburse 50% of the Dentist's Usual and Reasonable Charge after the Deductible has been met for a non-Preferred Care Provider. Please note that the Dentist's actual charge may be greater than the Usual and Reasonable Charge, in which case the Covered Person must pay the difference.

AETNA DENTAL MAINTENANCE ORGANIZATION® (DMO®) OPTION

Primary Care Dentists agree to provide services to Covered Persons at reduced cost (Negotiated Charges). The DMO option offers an in-network benefit only. There is not an out-of-network feature under the DMO. If a Covered Person goes to a Dentist who is a non-Primary Care Dentist, the Covered Person will be required to pay the full amount of the claim.

When an Employee or LTD Participant enrolls in the DMO option, the Employee and LTD Participant and each of the Employee's and LTD Participant Dependents will choose a Primary Care Dentist who will provide your In-Network dental care. In order to locate a Primary Care Dentist, you should consult the DMO Directory of Primary Care Dentists and select a DMO Primary Care Dentist near you for the type of services you need. Contact the Aetna Member Services to request a free copy of the DMO Primary Care Dentist Directory or for assistance with finding a DMO Primary Care Dentist. You can also find this information at the Aetna website: www.aetna.com.

Advantages of using DMO option Primary Care Dentists:

- No Deductible
- No claim forms
- No annual maximum benefit, and
- No Lifetime maximum for orthodontic treatment.

Changing Your Primary Care Dentist

You can request to change your Primary Care Dentist at any time (but no more than once a month) by calling the Claims Administrator. Your new choice will take effect on the first day of the next month, if you call the Claims Administrator no later than the 15th of the month.

Note: The DMO option and Primary Care Dentists are not available in all locations. Please call the Claims Administrator to confirm DMO option availability before enrolling.

Out-of-Area Emergency Coverage

You must first call the Claims Administrator to obtain approval and an authorization number to provide to the treating dentist. The below information is for Covered Persons not living in Arizona, Illinois, Massachusetts, North Carolina, Pennsylvania, and Texas as they have their own state laws as it pertains to Out of Area Emergency benefits in the DMO plan.

Out-of-Area Emergency coverage consists of coverage for treatment by a Non-Participating Dental Provider for the palliative (pain relieving or stabilizing treatment only) treatment of an emergency condition. Authorization for emergency care would be given to the Covered Person who is outside of the 50 mile radius of their home address. When the claim comes in with the authorization for care of an emergency care, a benefit will be paid for 100% of the reasonable charges (R&C) incurred by the Covered Person, and the Covered Person is responsible for any amount not paid for by the Plan.

AETNA DMO DENTAL OPTION Summary of Coverage	
Aetna DMO Dental Plan Features	**Aetna DMO In-Network Only**
Deductible	None
Annual Benefit Maximum	None
Preventive Services • Oral examinations (4 per Calendar Year) • Cleanings, including scaling and polishing (2 per Calendar Year) • Fluoride (One treatment per Calendar Year for Covered Persons under age 18) • Sealants (Once every three rolling years on permanent molars only) • Bitewing X-rays (2 sets per Calendar Year) • Full Mouth series X-rays (1 set every three rolling years)	100% of Negotiated Charge
Basic Services • Root canal therapy (anterior/bicuspid teeth) • Amalgam (silver) fillings • Composite fillings (anterior teeth only) • Scaling and root planning (4 separate quads per two rolling years) • Periodontal maintenance - following surgical therapy -(2 per Calendar Year) • Uncomplicated extractions • Surgical removal of erupted tooth	100% of Negotiated Charge
Major Services • Molar root canal therapy • Osseous surgery • General anesthesia/intravenous sedation • Inlays, onlays or crowns • Full & partial dentures • Denture repairs • Oral surgery (except for impacted wisdom teeth) Note: Surgical removal of impacted wisdom teeth is not covered under the Aetna DPO Dental Plan. Oral Surgery for surgical removal of impacted wisdom teeth is considered a covered medical expense under the Evonik Medical Plan.	60% of Negotiated Charge
Orthodontic Services (Adult and Children)	60% of Negotiated Charge

AETNA DMO DENTAL OPTION
COVERED DENTAL EXPENSES

The following is a list of Covered Dental Expenses under the Aetna DMO dental option. All services are subject to the Plan's maximum annual benefit, age and frequency limits. Refer to the *General Exclusion Section* for the Aetna DPO and Aetna DMO dental options for information on dental expenses that are not covered under the Plan**.**

Preventive Services. The Plan will pay 100% of Negotiated Charges. Below is a list of Covered Dental Expenses for preventive care services:

- Oral examinations (4 per Calendar Year)
- Cleanings, including scaling and polishing (2 per Calendar Year)
- Fluoride (One treatment per Calendar Year for Covered Persons under age 18)
- Sealants (Once every three rolling years on permanent molars only)
- Bitewing X-rays (2 sets per Calendar Year)
- Full Mouth series X-rays (1 set every three rolling years)

Basic Services. The Plan will pay 100% of the Negotiated Charges. Below is a list of Covered Dental Expenses for basic care services:

- Root canal therapy (anterior/bicuspid teeth)
- Amalgam (silver) fillings
- Composite fillings (anterior teeth only)
- Scaling and root planning (4 separate quads per two rolling years)
- Periodontal maintenance - following surgical therapy - (2 per Calendar Year)
- Uncomplicated extractions
- Surgical removal of erupted tooth

Major Services. The Plan will pay 60% of the Negotiated Charges. Below is a list of Covered Dental Expenses for major care services:

- Molar root canal therapy
- Osseous surgery
- General anesthesia/intravenous sedation
- Inlays, onlays or crowns
- Full & partial dentures
- Denture repairs
- Oral surgery (except for impacted wisdom teeth)

Impacted Wisdom Teeth

Surgical removal of impacted wisdom teeth is not covered under the Aetna DMO Dental Plan. Oral Surgery for surgical removal of impacted wisdom teeth is covered under the Evonik Medical Plan**.**

GENERAL EXCLUSIONS
AETNA DPO AND AETNA DMO DENTAL OPTIONS

Coverage is not provided for the following charges:

- Services or supplies provided before you were covered by the Plan.
- Charges for services and supplies not necessary, as determined by the Claims Administrator, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the Covered Persons attending physician or Dentist.
- Charges for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the Covered Person's Dentist.
- Charges for or in connection with services or supplies that are, as determined by the Claims Administrator, experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
  - there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  - if required by the FDA, approval has not been granted for marketing; or
  - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
  - the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.
- Charges for services of a resident physician or intern rendered in that capacity.
- Charges that are made only because there is dental coverage. Charges that a Covered Person is not legally obliged to pay.
- To the extent allowed by under applicable law, charges for services and supplies:
  - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
  - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled *Effect of Benefits Under Other Plans Not Including Medicare*. In addition, this exclusion will not apply to: a plan established by a government for its own Covered Persons or their Dependents; or Medicaid.)
- Charges for routine dental exams or other preventive services and supplies, except to the extent coverage for such exams, services, or supplies is specifically provided.
- Charges for acupuncture therapy. Not excluded is acupuncture when it is performed by a physician as a form of anesthesia in connection with surgery that is covered under this Plan.

GENERAL EXCLUSIONS
AETNA DPO AND AETNA DMO DENTAL OPTIONS

- Charges for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to repair an injury. Covered surgery must be performed:
  - in the Calendar Year of the accident which causes the injury; or
  - in the next Calendar Year.

  Facings on molar crowns and pontics will always be considered cosmetic.
- Charges for a service or supply furnished by a Preferred Care Provider in excess of such provider's Negotiated Charge for that service or supply.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage. These excluded charges will not be used when figuring benefits.

Covered Dental Expenses do not include, and no benefits are payable for charges for:

- Any dental services and supplies which are covered in whole or in part under any other part of this Plan. Any dental services and supplies which are covered in whole or in part under any other plan of group benefits provided by the Company or the Plan Sponsor will be subject to coordination of benefits rules;
- Charges for surgical implants under the Aetna DMO.
- Charges for services and supplies to diagnose or treat a disease or injury that is an:
  - occupational disease; or
  - occupational injury;
- Charges for services not listed in the Summary of Coverage;
- Charges for other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion.
- Charges for any of the following services:
  - an appliance, or modification of one, if an impression for it was made before the person became a Covered Person (or a covered person under the Company's dental plan for employees, LTD Participants and Retirees);
  - a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a Covered Person (or a covered person under the Company's dental plan for employees, LTD Participants and Retirees);
  - root canal therapy, if the pulp chamber for it was opened before the person became a Covered Person (or a covered person under the Company's dental plan for employees, LTD Participants and Retirees);
- Charges for services intended for treatment of any jaw joint disorder; except as specifically provided;
- Charges for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth;
- Charges for orthodontic treatment, except as specifically provided;
- Charges for general anesthesia and intravenous sedation, unless done in conjunction with another necessary covered service;
- Charges for treatment by other than a physician or Dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental

hygienist. In this case, the treatment must be given under the supervision and guidance of a Dentist;

- Charges in connection with a service given to a person age 5 or more if that person becomes a Covered Person other than: (i) during the first 31 days the person is eligible for this coverage; or (ii) as prescribed for any period of annual enrollment agreed to by the Plan Administrator and the Claims Administrator. This does not apply to charges incurred:
  - after the end of the twelve month period starting on the date the person became a Covered Person; or
  - as a result of accidental injuries sustained while the person was a Covered Person; or
  - for a service in the Summary of Coverage that applies shown under the headings Visits and X-rays, Visits and Exams, and X-ray and Pathology;
  - Charges for services given by a Non Preferred Provider to the extent that the charges exceed the amount payable for the services shown in the Summary of Coverage that applies;
- Charges for a crown; cast; or processed restoration unless:
  - it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
  - the tooth is an abutment to a covered partial denture or fixed bridge;
- Charges for pontics, crowns, cast or processed restorations made with high noble metals; except as specifically provided;
- Charges for plaque control;
- Charges for gold foil restorations;
- Charges for use of any facility such as a hospital in which dental services are rendered, except where the Claims Administrator determines the use of such a facility was medically necessary.
- Charges for infection control;
- Services or expenses for intraoral delivery of or treatment by chemotherapeutic agents;
- Charges for surgical removal of impacted wisdom teeth;
- Charges for services which are not Covered Dental Expenses;
- Charges for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services;
- Adjustments charges for services to alter vertical dimension (work done or appliance used to increase the distance between nose and chin); to restore or maintain occlusion (work done or appliance used to change the way the top and bottom teeth meet or mesh); to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint;
- Charges for services or supplies furnished after the date Plan coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, benefits for Covered Dental Expenses incurred for the following procedures will be payable as though the coverage had continued in force:

  - A prosthetic device, such as full or partial dentures, if the Dentist took the impression and prepared the abutment teeth while the patient was a Covered Person in the Plan, and delivers and installs the device within two months following termination of coverage;
  - A crown, if the Dentist prepared the tooth for the crown while the patient was a Covered Person in the Plan, and installs the crown within two months following termination of coverage; and
  - Root canal therapy if the Dentist opened the tooth while the patient was a Covered Person in the Plan, and completed the treatment within two months following termination of coverage;
- Education charges for instruction in oral hygiene, plaque control, or diet;
- Charges in excess of the Usual and Reasonable Charge for the service or supply received or charges in excess of any maximum payable under this Plan;
- Charges for services rendered by a person who is an immediate relative of, or who ordinarily resides with, the Covered Person requiring treatment. "Immediate relative" means the Spouse, child, brother, sister, or parent of the Covered Person, whether by birth, adoption or marriage;
- Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, a labor union, trustee or similar person or group;
- Charges for injury or illness which arises out of the course of any employment, including but not limited to, self-employment (when the Covered Person is required to obtain a federal Tax ID number), ranching, farming, roofing, mechanics, etc;
- Charges for missed appointments or completion of claim forms;
- Charges that are covered under a medical plan or medical coverage;
- Charges for a more expensive course of treatment in all cases involving Covered Dental Expenses in which the provider or Dentist and the Covered Person select a more expensive course of treatment than is customarily provided by the dental profession, in lieu of a more cost effective alternative treatment. Coverage under the Plan will be based upon the Covered Dental Expenses allowed for the less costly procedure;
- Charges for unnecessary care, treatment, services or supplies, including replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability;
- Those charges for services or supplies which are not recommended and approved by a Dentist or physician;
- Charges for repairing and/or re-cementing of crowns, inlays, bridgework or dentures and relining of dentures;
- Charges for replacement of a lost, missing, or stolen appliances (listed below) and charges for replacement of appliances that have been damaged due to abuse, misuse, or neglect;
  - dentures;
  - crowns;
  - inlays;
  - onlays;

GENERAL EXCLUSIONS
AETNA DPO AND AETNA DMO DENTAL OPTIONS

  - bridgework
- Charges for replacements other than replacement of a lost, missing or stolen appliances or charges for replacement of appliances that have been damaged due to abuse misuse, or neglect::
  - Charges for replacement made within five years after the last placement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge.
    This exclusion is waived if replacement is needed because the appliance, crown, inlay, onlay or bridge, while in the oral cavity, is damaged beyond repair due to an accidental injury sustained by the Covered Person. (Damage resulting from biting or chewing is not considered an accidental injury.). Replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth is covered if:
    - The teeth were extracted while the Covered Person was covered under the Plan;
    - The existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or
    - The existing denture is an immediate temporary denture and necessary replacement by the permanent denture takes place within 12 months;
- Charges for self-inflicted injury for intentionally self-inflicted sickness or injury unless it is a result of a medical condition (either physical or mental);
- Extra charges incurred because care is provided by multiple providers. In the event a Covered Person transfers from the care of one provider to that of another during a course of treatment or if more than one provider performs services for one or more dental procedures, the Plan will consider only such expenses as would be appropriate had a single provider performed the service. An Eligible Dental Expense in this case will be based on the Usual and Reasonable Charge for the procedure if performed by a single provider;
- Charges for injury or illness as a result of war, declared or undeclared, or any act of war or act of aggression by any country; or voluntary participation in a riot;
- Charges for services or expenses of any kind unless a claim is submitted by or for a Covered Person in the form prescribed by the Claims Administrator and the claim is received by the Claims Administrator; and
- Charges for services or expenses of any kind for which a claim is received by the Claims Administrator later than one year after the date services were performed.

BLUE CROSS AND BLUE SHIELD OF ALABAMA PPO DENTAL OPTION

The Blue Cross Blue Shield of Alabama dental option is offered to Employees, LTD Participants and Stockhausen, LA Retirees who retired prior to April 26, 2006 whose state of primary residence is located in the states of Alabama, Arkansas, Georgia, Florida, Illinois, Louisiana, Michigan, Mississippi, and North Carolina.

The Blue Cross and Blue Shield of Alabama PPO allows you the flexibility to choose a Preferred Dentist or a non-Preferred Dentist each time you need dental services. Preferred Dentists agree to provide services to Covered Persons at a reduced fee (Negotiated Charges). You or your Dependents do not have to choose a Preferred Dentist.

In order to receive care at a lower cost to the Covered Person and the Plan, a Covered Person should try and obtain dental care from a Preferred Dentist. Another advantage of using Preferred Dentists is that there are no claim forms to submit. Your Preferred Dentist will submit a claim to the Claims Administrator for payment and then bill you directly for any Coinsurance that you must pay. If you use a non-Preferred Dentist, on the other hand, you will need to pay the Dentist and then submit a Claim for reimbursement.

The covered services are the same regardless of whether you use a Preferred Dentist or a non-Preferred Dentist. When you obtain care from a Preferred Dentist, your out of pocket expenses will be lower than when you use a non-Preferred Dentist.

Contact the Blue Cross and Blue Shield of Alabama Member Services to request a free copy of a Directory of Preferred Dentists or for assistance with finding a Preferred Dentist. You can also find this information at the Blue Cross and Blue Shield of Alabama website: www.bsbsal.com.

Blue Cross Blue Shield PPO Dental Option Summary of Coverage		
Features	**In-Network**	**Out-of-Network**
Deductible (per Plan Year) • Individual • Family (maximum of 3 Deductibles per family)	 $ 50 $150	 $ 50 $150
Orthodontic Deductible - Separate Lifetime Deductible • Per Individual	 $50	 $50
Annual Benefit Maximum (per Plan Year) (applies to all services) • Per Individual	 $1,500	 $1,500
Lifetime Benefit for Orthodontic Services • Per Individual	 $1,500	 $1,500

Diagnostic and Preventive Services
• Dental exams up to twice per Plan Year.
• Dental X-ray exams:
  • Full mouth x-rays, one set during any 36 month period;
  • Bitewing x-rays, up to twice per Plan Year; and
  • Other dental x-rays, used to diagnose a specific condition.
• Routine cleanings, twice per Plan Year.
• Tooth sealants on teeth numbers 3, 14, 19, and 30, limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of $20 per tooth and limited to the first permanent molars of children through age 13.
• Fluoride treatment for children through age 18 twice per Plan Year.
• Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18.
	100% of Preferred Dental Schedule	100% of Usual and Reasonable Charge

Restorative • Fillings made of silver amalgam and synthetic tooth color materials. • Simple tooth extractions. • Direct pulp capping, removal of pulp, and root canal treatment. • Repairs to removable dentures. • Emergency treatment for pain.	80% of Preferred Dental Schedule after Deductible	80% of Usual and Reasonable Charge after Deductible

Blue Cross Blue Shield PPO Dental Option Summary of Coverage		
Features	**In-Network**	**Out-of-Network**
Supplemental Services • Oral surgery to treat fractures and dislocations of the jaw, to diagnose and treat mouth cysts and abscesses, and for tooth **extractions except for impacted teeth.** Note: Surgical removal of impacted wisdom teeth is not covered under the Plan. Oral Surgery for surgical removal of impacted wisdom teeth is considered a covered medical expense under the Evonik Corporation Medical Plan. • General anesthesia given for oral or dental surgery. This means drugs injected or inhaled for relaxation or to lessen pain, or to make unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide. • Treatment of the root tip of the tooth including its removal.	80% of Preferred Dental Schedule after Deductible	80% of Usual and Reasonable Charge after Deductible
Prosthetic Services • Full or partial dentures. • Fixed or removable bridges. • Inlays, onlays, or crowns to restore diseased or accidentally broken teeth, if less expensive fillings are not adequate.	50% of Preferred Dental Schedule after Deductible	50% of Usual and Reasonable Charge after Deductible
Periodontic Services • Periodontic exams twice each 12 months. • Removal of diseased gum tissue and reconstructing gums. • Removal of diseased bone. • Reconstruction of gums and mucous membranes by surgery. • Removing plaque and calculus below the gum line for periodontal disease.	50% of Preferred Dental Schedule after Deductible	50% of Usual and Reasonable Charge after Deductible
Orthodontic Services (Children)	50% of the Preferred Dental Schedule subject to a separate $50 Lifetime Deductible for Dependent children up to age 26. Limited to a separate Lifetime maximum of $1,500	50% of Usual and Reasonable Charge after Deductible subject to a separate $50 Lifetime Deductible for Dependent children up to age 26. Limited to a separate Lifetime maximum of $1,500.

BLUE CROSS AND BLUE SHIELD OF ALABAMA PPO DENTAL OPTION

EXPLANATION OF BENFITS

Annual Maximum Benefit. There is an per individual annual maximum benefit per Plan Year of $1,500 for diagnostic and preventive, restorative, supplemental, prosthetic and periodontic services. Once an individual has reached the $1,500 annual maximum benefit, no additional benefits will be paid for that individual under the Plan for that Plan Year. There is a separate annual maximum benefit for in-network care and out-of-network care. Benefits paid for orthodontia do not count toward the annual maximum.

Lifetime Maximum for Orthodontic Services. There is a separate $1,500 orthodontia Lifetime benefit maximum per individual. Once the per individual Lifetime benefit maximum has been reached for orthodontic services, no additional orthodontic benefits will be paid for that individual under the Plan. Orthodontic services are limited to Dependent children up to age 26. Benefits will be subject to any applicable benefit limits. Benefits paid for orthodontia do not count toward the annual maximum benefit.

Annual Individual Deductible. Your per Plan Year Deductible is the amount you must pay for Covered Dental Expenses each Plan Year before most benefits are paid by the Plan. Preventive care benefits are not subject to the Deductible; the Plan will cover your preventive care Covered Dental Expenses even if you have not yet reached your Deductible for the Calendar Year. Benefits will be subject to any applicable benefit limits. There is a separate deductible for in-network care and out-of-network care.

Annual Family Deductible. The individual per Plan Year Deductible applies to all Covered Persons. If you have family coverage, then all Covered Persons in your family are considered to have satisfied the individual Deductible once the family Deductible is satisfied. The family Deductible is the total amount you must pay for Covered Dental Expenses for Covered Persons in your family each Plan Year before most benefits are paid by the Plan for Covered Persons who have not independently satisfied the individual Deductible. In other words, once Covered Dental Expenses incurred in a Calendar Year by you and your covered Dependents equal the family Deductible limit, you and all of your covered Dependents will be deemed to have met the individual Deductible limit for the rest of that Calendar Year. Preventive care benefits are not subject to the Deductible; the Plan will cover your preventive care Covered Dental Expenses even if you have not yet reached your Deductible for the Calendar Year. There is a separate $50 Lifetime orthodontia Deductible per individual. Benefits will be subject to any applicable benefit limits. There is a separate deductible for in-network care and out-of-network care.

Lifetime Deductible for Orthodontia Services. There is a separate $50 Lifetime orthodontia Deductible per individual. Orthodontic services are limited to Dependent children up to age 26. Benefits will be subject to any applicable benefit limits.

BLUE CROSS AND BLUE SHIELD OF ALABAMA PPO DENTAL OPTION

EXPLANATION OF BENFITS

Alternate Treatment Rule

If more than one service can be used to treat a Covered Person's dental condition, the Claims Administrator may decide to authorize coverage only for a less costly covered service, provided that both of the following terms are met:

- The service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- The service selected must meet broadly accepted national standards of dental practice.

Impacted Wisdom Teeth

Surgical removal of impacted wisdom teeth is not covered under the Blue Cross and Blue Shield of Alabama PPO coverage option. Oral Surgery for surgical removal of impacted wisdom teeth is covered under the Evonik Medical Plan.

Replacement Rule

The Plan will pay the cost of the replacement of existing dentures, fixed bridgework, veneers, or crowns if the old one cannot be fixed. If one of these items can be fixed, the Plan will pay the cost of fixing the item (this includes repairs to fixed dentures). The Plan will reimburse the cost of the replacement of these items only once every five years.

BLUE CROSS BLUE SHIELD OF ALABAMA PPO DENTAL OPTION
COVERED DENTAL EXPENSES

The following is a list of Covered Dental Expenses under the Blue Cross and Blue Shield of Alabama PPO option. All services are subject to the Plan's maximum annual benefit, age and frequency limits. Refer to the *General Exclusions* section for information on dental expenses that are not covered under the Plan**.**

Diagnostic and preventive services. The Plan will pay 100% of the Preferred Dental Schedule if you use a Preferred Dentist. When you use a non-Preferred Dentist, the Plan will cover 100% of the Usual and Reasonable Charge. Please note that the Dentist's actual charge may be greater than the Usual and Reasonable Charge, in which case the Covered Person must pay the difference. Below is a list of Covered Dental Expenses for diagnostic and preventive services:

- Dental exams - up to twice per Plan Year
- Dental X-ray exams
- Full mouth x-rays - one set during any 36 month period
- Bitewing x-rays - up to twice per Plan Year
- Other dental x-rays, used to diagnose a specific condition.
- Routine cleanings - twice per Plan Year
- Tooth sealants on teeth numbers 3, 14, 19, and 30 - limited to one application per tooth each 48 months. Benefits are limited to a maximum payment of $20 per tooth and limited to the first permanent molars of children through age 13
- Fluoride treatment for children through age 18 - twice per Plan Year
- Space maintainers (not made of precious metals) that replace prematurely lost teeth for children through age 18

Restorative services. The Plan will reimburse up to 80% of the Preferred Dental Schedule after the Plan Year Deductible has been met for a Preferred Dentist or up to 80% of the Usual and Reasonable Charge after the Plan Year Deductible for a non-Preferred Dentist. Please note that the Dentist's actual charge may be greater than the Usual and Reasonable Charge, in which case the Covered Person must pay the difference. Below is a list of Covered Dental Expenses for restorative services:

- Fillings made of silver amalgam and synthetic tooth color materials
- Simple tooth extractions
- Direct pulp capping, removal of pulp, and root canal treatment
- Repairs to removable dentures
- Emergency treatment for pain

Supplemental services. The Plan will reimburse up to 80% of the Preferred Dental Schedule after the Plan Year Deductible has been met for a Preferred Dentist or 80% of the Usual and Reasonable Charge after the Plan Year Deductible for a non-Preferred Dentist. Please note that the Dentist's actual charge may be greater than the Usual and Reasonable Charge, in which case the Covered Person must pay the difference. Below is a list of Covered Dental Expenses for supplemental services:

BLUE CROSS BLUE SHIELD OF ALABAMA DENTAL OPTION
COVERED DENTAL SERVICES

- Oral surgery to treat fractures and dislocations of the jaw, to diagnose and treat mouth cysts and abscesses, and for tooth extractions, **except for surgical removal of impacted wisdom teeth.**
- General anesthesia given for oral or dental surgery, **except for surgical removal of impacted wisdom teeth.** This means drugs injected or inhaled for relaxation or to lessen pain, or to make unconscious, but not analgesics, drugs given by local infiltration, or nitrous oxide.
- Treatment of the root tip of the tooth including its removal.

Note: Surgical removal of impacted wisdom teeth is not covered under the Blue Cross and Blue Shield of Alabama PPO dental coverage option. Oral Surgery for surgical removal of impacted wisdom teeth is considered a covered medical expense under the Evonik Corporation Medical Plan.

Prosthetic services. The Plan will reimburse up to 50% of the Preferred Dental Schedule after the Plan Year Deductible has been met for a Preferred Dentist or 50% of the Usual and Reasonable Charge for a non-Preferred Dentist after the Deductible has been met. Please note that the Dentist's actual charge may be greater than the Usual and Reasonable Charge, in which case the Covered Person must pay the difference. Below is a list of Covered Dental Expenses for prosthetic services:

- Full or partial dentures.
- Fixed or removable bridges.
- Inlays, onlays, or crowns to restore diseased or accidentally broken teeth, if less expensive fillings are not adequate.

Periodontic services. The Plan will reimburse up to 50% of the Preferred Dental Schedule after the Plan Year Deductible has been met for a Preferred Dentist or 50% of the Usual and Reasonable Charge for a non-Preferred Dentist after the Deductible has been met. Please note that the Dentist's actual charge may be greater than the Usual and Reasonable Charge, in which case the Covered Person must pay the difference. Below is a list of Covered Dental Expenses for periodontic services:

- Periodontic exams - twice each 12 months
- Removal of diseased gum tissue and reconstructing gums
- Removal of diseased bone
- Reconstruction of gums and mucous membranes by surgery
- Removing plaque and calculus below the gum line for periodontal disease

Orthodontic services. The Plan will reimburse up to 50% of a Preferred Dental Schedule for a Preferred Dentist, up to 50% of the Usual and Reasonable Charge for a non-Preferred Dentist. Orthodontic services are subject to a separate $50 Lifetime Deductible and a separate Lifetime maximum of $1,500. Orthodontic services are Covered Dental Expenses only for Dependent children up to age 26.

GENERAL EXCLUSIONS
BLUE CROSS BLUE SHIELD OF ALABAMA PPO DENTAL OPTION

Coverage is not provided for the following charges:

- Dental treatment due to an illness, injury, disease, or physical condition caused by an act of war, riot, insurrection, civil disobedience, nuclear explosion accident, or major disaster;
- Charges for services and supplies to diagnose or treat a disease or injury that is an:
    - occupational disease; or
    - occupational injury;
- Charges for injury or illness which arises out of the course of any employment, including but not limited to, self-employment (when the Covered Person is required to obtain a federal Tax ID number), ranching, farming, roofing, mechanics, etc;
- Charges that are covered under a medical plan or medical coverage;
- Charges for self-inflicted injury for intentionally self-inflicted sickness or Injury unless it is a result of a medical condition (either physical or mental);
- Extra charges incurred because care is provided by multiple providers. In the event a Covered Person transfers from the care of one provider to that of another during a course of treatment, or if more than one provider performs services for one or more dental procedures, the Plan will consider only such expenses as would be appropriate had a single provider performed the service. An Eligible Dental Expense in this case will be based on the Usual and Reasonable Charge for the procedure if performed by a single provider;
- Any dental services and supplies which are covered in whole or in part under any other part of this Plan. Any dental services and supplies which are covered in whole or in part under any other plan of group benefits provided by the Company or the Plan Sponsor shall be subject to coordination of benefits rules;
- Education charges for instruction in oral hygiene, plaque control, or diet;
- Charges for immediate relative services rendered by a person who is an immediate relative of, or who ordinarily resides with, the Covered Person requiring treatment. “Immediate relative” means the Spouse, child, brother, sister or parent of the Covered Person, whether by birth, adoption or marriage;
- Charges for services performed by a physician or other dental provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;
- Services received from a dental or medical department maintained by, or on behalf of, an employer, a mutual benefit association, labor union, trustee or similar group;
- Dental services to the extent coverage is available to the patient under any other Blue Cross and Blue Shield contract;
- Services for which benefits are payable under Medicare or which are provided for under Workers' Compensation Laws or Employee's Liability Law, or which are provided for by any government agency;
- Services or supplies ordered before coverage commences, or received (installed) after coverage ends, except that prosthetic devices such as dentures, bridges, crowns, inlays, onlays and their fittings are covered if they are ordered from the

laboratory while insured and received within 60 days after coverage ends. Also, root canal treatment which began before termination of coverage and that cannot be completed until afterwards are covered;

- Services not billed by a Dentist, or services rendered by a Dentist or a dental hygienist beyond the scope of his license, or services which are not necessary or which are not recommended by the attending Dentist;
- Charges for unnecessary care, treatment, services, or supplies, including replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability;
- Charges for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the Covered Person's Dentist;
- Charges for use of any facility such as a hospital in which dental services are rendered, except where the Claims Administrator determines the use of such a facility was medically necessary;
- Charges for services or supplies which do not meet the accepted standards of dental practice, including charges for services or supplies which are experimental in nature.
- Charges for a service or supply furnished by a Preferred Dentist in excess of such provider's Preferred Dental Schedule for that service or supply;
- Charges for services given by a non-Preferred Provider to the extent that the charges exceed the amount payable for the services shown in the Summary of Coverage that applies;
- Charges for a more expensive course of treatment in all cases involving Covered Dental Expenses in which the provider or Dentist and the Covered Person select a more expensive course of treatment than is customarily provided by the dental profession, in lieu of a more cost effective alternative treatment. Coverage under the Plan will be based upon the Covered Dental Expenses allowed for the less costly procedure;
- Charges for failure to keep appointments or completion of insurance forms,
- Charges which would not be made if coverage under the Plan were not in effect;
- Charges for services not listed in the Summary of Coverage;
- Charges for routine dental exams or other preventive services and supplies, except to the extent coverage for such exams, services, or supplies is specifically provided.
- Charges for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services;
- Anesthetic services performed by and billed for by a Dentist other than the attending Dentist or his/her assistant;
- Dental services with respect to congenital malformations or primarily for cosmetic or anesthetic purposes;
- Charges for orthodontic treatment, except as specifically provided;
- Charges for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth for Dependent children through age 18;
- Spare or duplicate prosthetic devices or appliances;
- Services rendered as a result of loss or theft of an artificial denture or orthodontic appliance (normally these losses are covered by homeowners insurance), or service and supplies in connection with the replacement or repair of an orthodontic appliance;

GENERAL EXCLUSIONS
BLUE CROSS BLUE SHIELD OF ALABAMA PPO DENTAL OPTION

- Appliances (other than full dentures) or fillings primarily used to increase vertical dimension or restore occlusion;
- Charges for repairing and/or re-cementing of crowns, inlays, bridgework, or dentures and relining of dentures;
- Charges for a crown, cast, or processed restoration unless:
    - it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
    - the tooth is an abutment to a covered partial denture or fixed bridge;
- Charges for pontics, crowns, cast, or processed restorations made with high noble metals, except as specifically provided;
- Charges for gold foil restorations;
- Charges for other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion;
- Adjustments charges for services to alter vertical dimension (work done or appliance used to increase the distance between nose and chin); to restore or maintain occlusion (work done or appliance used to change the way the top and bottom teeth meet or mesh); to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint;
- Charges for surgical implants, oral hygiene, and dietary instruction, or for plague control programs;
- Charges for infection control;
- Services or expenses for intraoral delivery of or treatment by chemotherapeutic agents;
- Charges for surgical removal of impacted wisdom teeth;
- Charges for services intended for treatment of any jaw joint disorder; except as specifically provided;
- Charges for services or expenses of any kind unless a claim is submitted by or for a Covered Person in the form prescribed by the Claims Administrator and the claim is received by the Claims Administrator; and
- Charges for services or expenses of any kind for which a claim is received by the Claims Administrator later than one year after the date services were performed.

Any exclusion listed above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage. These excluded charges will not be used when figuring benefits.

METLIFE BASIC CORE AND METLIFE PREMIUM DENTAL PLAN

The MetLife Dental Plan is offered to Employees and LTD Participants with a choice of either the Basic Core option or the Premium option. Both options provide comprehensive coverage for many dental procedures and are offered to help Covered Persons to pay for dental care.

The MetLife Dental coverage options allows you the flexibility to choose a Preferred Dentist (called PDP Dentists) or a non-PDP Dentist each time you need dental services. PDP Dentists agree to provide services to Covered Persons at a reduced fee (Negotiated Charge). A Covered Person can receive benefits at a lower cost under the Plan by using a PDP Dentist. In order to maximize benefits Covered Persons should obtain dental care from a PDP Dentist. Another advantage of using PDP Dentist is that there are no claim forms to submit. Your PDP Dentist will submit a claim to the Claims Administrator for payment and then bill you directly for any Coinsurance that you must pay. If you use a Dentist who is not a PDP Dentist, on the other hand, you will need to pay the Dentist and then submit a Claim for reimbursement.

The covered services are the same regardless of whether you use a PDP Dentist or a non-PDP Dentist. However, when you obtain care from a PDP Dentist, your out of pocket expenses will be lower than when you use a non-PDP Dentist.

In order to locate a PDP Dentist, you should consult the Directory of PDP Dentists and select a PDP Dentist near you for the type of services you need. Contact Member Services to request a free copy of the PDP Dentist Directory or for assistance with finding a PDP Dentists. You can also find this information at the MetLife website www.metlife.com.

Each Plan Year, benefits will be paid for Actives and LTD participants once you satisfy any applicable deductible and coinsurance. Payment will be made as described in the section of this document in the "SUMMARY OF COVERAGE" chart. No benefits will be paid in excess of the maximum benefit amount or any listed limit of the Plan.

You may choose coverage under either the Basic Core Plan or the Premium Plan. Certain limitations and exclusions apply to both, and it is important that you refer to the provisions below in order to know the details about your particular benefits. Either way, after you pay the annual Deductible, the Plan will pay benefits according to the chart and provisions below.

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Dental Benefits.

METLIFE BASIC CORE DENTAL OPTION

SUMMARY OF METLIFE BASIC CORE DENTAL BENEFITS		
Feature	**In-Network**	**Out-of-Network**
Deductible (per Plan Year) • Per Individual	$ 25	$ 25
Annual Benefit Maximum (Per Plan Year (applies to Preventive, Basic and Major Services) • Per Individual	$1,000	$1,000
Lifetime Maximum for Orthodontics • Per Individual	$1,000	$1,000
Preventive and Diagnostic Services – Type A • Prophylaxis (cleanings), including polishing (twice a Plan Year) • Oral examinations (twice a Plan Year) • Fluoride (one course of treatment per Calendar Year for children up to age 19) • Bitewing X-rays (twice a Plan Year) • Full Mouth series X-rays (limited to one set each 36 months) • Periapical • Pulp vitality tests • Sealants (one application every 3 years for permanent molars only, for children under age 15) • Space Maintainers – Fixed, removable and recementation unilateral or bilateral (adjustments within 6 months after installation up to age 23)	100% of Negotiated Charge	100% of Reasonable and Customary

SUMMARY OF METLIFE BASIC CORE DENTAL BENEFITS		
Features	**In-Network**	**Out-of-Network**
Basic Restorative Services – Type B • Apexification/recalcification • General anesthesia (w/oral surgery) Impacted wisdom teeth are covered under the Evonik Medical Plan • Amalgam restorations (primary, permanent, pin retained) • Crown, Denture, and Bridge Repair/Recementations • Existing dentures: o Adjustment o Replacement of broken tooth o Additions to partial denture o Relining upper or lower complete or partial denture • Frenulectomy • Incision and drainage of abscess • Muco-gingival surgery • Occlusal adjustment (limited or complete) • Oral antral fistula closure • Oral surgery (except surgical removal of impacted teeth) **NOTE: REMOVAL OF IMPACTED WISDOM TEETH IS NOT COVERED UNDER THE DENTAL PLAN. REMOVAL OF IMPACTED WISDOM TEETH ARE COVERED UNDER THE EVONIK MEDICAL PLANS.** • Periodontal prophylaxis • Periodontal surgery once per quadrant, every 36 months • Pedicle soft graft (single and multiple sites: o Pedical soft tissue graft o Free soft tissue graft • Periodontal maintenance treatments (cannot exceed four treatments in a Calendar Year) • Periodontal Scaling and root planning once per quadrant, every 24 months • Pulp capping (direct and indirect) • Removal of residual roots • Removal of tissue (hpyerplastic, pericoronal) • Resin restoration (primary, permanent, recementation of inlays or crowns) • Root canal treatment limited to once per tooth per 24 months	60% of Negotiated Charge after Deductible	60% of Reasonable and Customary after Deductible

Basic Restorative Services – Type B – continued • Silicate restoration • Sedative filling • Transplantation of tooth		
Major Restorative Services – Type C • Apicoectomy Dental Implants (1 every 60 months • Bridge pontics (1 replacement every 60 months, cast gold, porcelain, or plastic processed to gold) • Biopsy of oral tissue • Bridge abutments (1 replacement every 60 months, plastic with gold, porcelain fused to metal or gold) • Crowns– single restoration (limited to 1 per tooth every 60 months) plastic, plastic with gold, porcelain fused to metal, gold, stainless steel, crown build-up – pin retained, or post and core • Diagnostic cast • Gingivectomy • Gingival curettage • Gold foil restoration • Inlay restoration (metallic, porcelain/ceramic) (limited to 1 per tooth every 60 months) • New dentures o Temporary denture - permanent denture must be installed within 12 months of after the temporary denture was installed. • Onlay (limited to 1 per tooth every 60 months) • Osseous surgery • Osseous grafts • Root canal treatment limited once per tooth per 24 months • Stressbreaker • Therapeutic pulpotomy	40% of Negotiated Charge after Deductible	40% Reasonable and Customary Charge after Deductible
Orthodontic Services - Type D (Dependent children up to Age 26) – Type IV	50% of Negotiated Charge up to $1,000 Lifetime maximum	50% of Reasonable and Customary Charge up to $1,000 Lifetime maximum per individual.

METLIFE PREMIUM DENTAL OPTION

SUMMARY OF METLIFE PREMIUM DENTAL BENEFITS		
Features	**In-Network**	**Out-of-Network**
Deductible (per Plan Year) • Per Individual	$ 25	$ 25
Annual Benefit Maximum (Per Plan Year (applies to Preventive, Basic and Major Services) • Per Individual	$1,500	$1,500
Lifetime Maximum for Orthodontics • Per Individual	$1,800	$1,800
Preventive and Diagnostic Services – Type A • Initial oral examination • Periodic oral examinations (one set per Calendar Year for adults; two sets per Calendar Year for children, separated by a six-month period Plan) • Palliative treatment • Intaoral x rays: Complete bitewings (once every 36 months) • Periapical • Bitewings x-rays (maximum of twice in Calendar Year) • Occlusal film • Extraoral x-rays – Skull and facial bone, survey film Temporomandibular joint arthrogram Panormaic Other extraoral x-rays • Pulp vitality tests • Prophylaxis (twice in a Calendar Year) • Periodontal prophylaxis • Fluoride, topical application (once per Calendar Year up to age 19) • Space maintainers (up to age 23)	100% of Negotiated Charge	100% of Reasonable and Customary

METLIFE PREMIUM DENTAL OPTION

SUMMARY OF METLIFE PREMIUM DENTAL BENEFITS		
Features	**In-Network**	**Out-of-Network**
Basic Restorative Services – Type B • General anesthesia (w/oral surgery) • Amalgam restorations (primary, permanent, pin retained) • Silicate restoration • Resin restoration (primary, permanent, recementation of inlays or crowns) • Pulp capping (direct and indirect) • Metallic retainers • Gold foil restoration • Inlay restoration (metallic, porcelain/ceramic) Crown, Denture and Bridge Repair/ Recementations Periodontics • Periodontal surgery once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a year. • Onlay • Sedative filling	80% of Negotiated Charge after Deductible	80% of Reasonable and Customary after Deductible
Major Restorative Services – Type C • Occlusal adjustment (limited or complete) Therapeutic pulpotomy • Root canal therapy Apicoectomy • Gingivectomy • Gingival curettage • Osseous surgery • Osseous grafts • Pedicle soft graft (single and multiple sites:	50% of Negotiated Charge after Deductible	50% of Reasonable and Customary after Deductible

METLIFE PREMIUM DENTAL OPTION

o Pedical soft tissue graft o Free soft tissue graft o Occlusal equilibration o Scaling and root planning o Diagnostic cast o Muco-gingival surgery • Existing dentures: o Adjustment o Replacement of broken tooth o Additions to partial denture o Relining upper or lower complete or partial denture • New dentures • Temporary denture o Must be installed within 12 months after the temporary denture was installed. • Bridge pontics (1 replacement every 60 months, cast gold, porcelain, or plastic processed to gold) • Bridge abutments (1 replacement every 60 months, plastic with gold, porcelain fused to metal or gold) • Crowns – single restoration (limited to 1 per tooth every 60 months) plastic, plastic with gold, porcelain fused to metal, gold, stainless steel, crown build-up – pin retained, or post and core • Biopsy of oral tissue • Removal of residual roots • Root canal treatment limited to once per tooth per 24 months • Oral antral fistula closure • Transplantation of tooth • Cyst removal • Incision and drainage of abscess		

• Frenulectomy • Removal of tissue (hpyerplastic, pericoronal) • Apexification/recalcification • Special periodontal device • Stayplate • Stressbreaker • Oral surgery (except surgical removal of impacted wisdom teeth) • Apicoectomy Dental Implants (1 every 60 months) **NOTE: REMOVAL OF IMPACTED WISDOM TEETH IS NOT COVERED UNDER THE DENTAL PLAN. REMOVAL OF IMPACTED WISDOM TEETH ARE COVERED UNDER THE EVONIK MEDICAL PLANS.**		
Orthodontic Services - Type D (Dependent children up to Age 26) – Type IV	60% of Negotiated Charge with a Lifetime limit of $1,800 per individual	60% of Reasonable and Customary with a Lifetime limit of $1,800 per individual

METLIFE BASIC AND PREMIUM CORE BENEFITS
EXPLANATION OF BENEFITS

Annual Maximum Benefit. There is a per individual annual maximum benefit per Plan Year for preventive, basic and major services. Once an individual has reached the annual maximum benefit, no additional benefits will be paid for that individual under the Plan for that Plan Year. Benefits paid for orthodontia do not count toward the annual maximum benefit.

- Under the MetLife Basic Core dental option, the annual Per Plan Year maximum benefit per individual is $1,000.
- Under the MetLife Premium dental option, the annual Per Plan Year maximum benefit per individual is $1,500.

Lifetime Maximum for Orthodontic Services. There is a separate orthodontia Lifetime benefit maximum per individual. Once the per individual Lifetime benefit maximum has been reached for orthodontic services, no additional orthodontic benefits will be paid for that individual under the Plan. Benefits will be subject to any applicable benefit limits. Benefits paid for orthodontia do not count toward the annual maximum benefit.

- Under the MetLife Basic Core dental option, the per individual Lifetime maximum benefit is $1,000.
- Under the MetLife Premium dental option, the per individual Lifetime maximum Per Plan Year is $1,800.

Annual Individual Deductible. Your annual per Plan Year Deductible is the amount you must pay before most benefits are paid by the Plan. Preventive care benefits are not subject to the Deductible; the Plan will cover your preventive care Covered Dental Expenses even if you have not yet reached your Deductible for the Calendar Year.

Annual Family Deductible. The individual annual Plan Year Deductible applies to all Covered Persons. If you have family coverage, then all Covered Persons in your family are considered to have satisfied the individual Deductible once the family Deductible is satisfied. The family Deductible is the total amount you must pay for Covered Dental Expenses for Covered Persons in your family each Plan Year before most benefits are paid by the Plan for Covered Persons who have not independently satisfied the individual Deductible. In other words, once Covered Dental Expenses incurred in a Calendar Year by you and your covered Dependents equal the family Deductible limit, you and all of your covered Dependents will be deemed to have met the individual Deductible limit for the rest of that Calendar Year. Preventive care benefits are not subject to the Deductible; the Plan will cover your preventive care Covered Dental Expenses even if you have not yet reached your Deductible for the Calendar Year.

Alternate Benefits: If more than one service can be used to treat a Covered Person's dental condition, the Claims Administrator may decide to authorize coverage only for a less costly covered service provided that both of the following terms are met:

- The service selected must be deemed by the dental profession to be an appropriate method of treatment; and

- The service selected must meet broadly accepted national standards of dental practice.

If you and your Dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be:

- the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the Negotiated Charges or, if non PDP, the actual charge, for the service actually rendered and the Negotiated Charge or Reasonable and Customary fee (if non PDP) for the service upon which the plan benefit is based. To avoid any misunderstandings, MetLife suggests you discuss treatment options with your Dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your Dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plans reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each Plan Year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service.

Predetermination of Benefits: If your dental treatment is expected to cost $300 or more, you can send the Claims Administrator a claim form completed by your Dentist outlining the proposed procedures and the cost. The Claims Administrator will predetermine benefits before you receive the treatment and let you know ahead of time what the Plan will pay.

It is recommended that you use the predetermination of benefits procedure so you know what the planned treatment is, the available benefits, and your out-of-pocket expenses. The predetermination of benefits does not apply to emergency treatment, routine oral exams, x-rays, cleaning or fluoride treatments.

The percentages of coverage given on the Summary of Benefits chart are based on Reasonable and Customary Charges.

Impacted Wisdom Teeth

Surgical removal of impacted wisdom teeth is not covered under the MetLife Dental options. Oral Surgery for surgical removal of impacted wisdom teeth is covered under the Evonik Corporation Medical Plan.

METLIFE BASIC CORE AND PREMIUM DENTAL OPTIONS

COVERED DENTAL EXPENSES

Type A - Preventive:

- Prophylaxis (cleanings) - two per Calendar Year Prophylaxis (cleanings)
- Oral Examinations - two exams per Calendar Year Oral Examinations
- Topical Fluoride Applications - one fluoride treatment per Calendar Year for Dependent children up to 19th birthday.
- Full mouth X-rays - one per 36 months.
- Bitewing X-rays: two sets per Calendar Year
- Space Maintainers • Space Maintainers for Dependent children up to 23rd birthday.

Type B - Basic Restorative:

- Crowns/Inlays/Onlays Replacement - once every 60 months,
- Endodontics - Root canal treatment limited to once per tooth per 24 months.
- General Anesthesia - when dentally necessary in connection with oral surgery, extractions or other Covered Dental Expenses. General Anesthesia for impacted wisdom teeth is covered under the Evonik Medical Plan.
- Periodontal scaling and root planning - once per quadrant, every 24 months.
- Periodontal surgery - once per quadrant, every 36 months.
- Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a Calendar Year.

Type C - Major Restorative:

- Dentures and bridgework replacement - one every 10 years.
- Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.

Type D - Orthodontia

- Your Children, up to age 26, are covered while Dental Insurance is in effect.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Orthodontic benefits end at cancellation of coverage.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.

METLIFE BASIC CORE AND PREMIUM DENTAL OPTIONS

GENERAL EXCLUSIONS

The MetLife Plan does not cover any expenses incurred for the following services, supplies, or treatment:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which MetLife deems experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic;
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
    - Scaling and polishing of teeth; or
    - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
    - Covered under any workers' compensation or occupational disease law;
    - Covered under any employer liability law;
    - For which the employer of the person receiving such services is not required to pay; or
    - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
    - Claim form completion;
    - Infection control such as gloves, masks, and sterilization of supplies; or

METLIFE BASIC CORE AND PREMIUM DENTAL OPTIONS

GENERAL EXCLUSIONS

  - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Initial installation or replacement of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Repair of implants;
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Fixed and removable appliances for correction of harmful habits;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture;
- Intra and extraoral photographic images;
- Oral surgery for impacted wisdom teeth. Oral surgery for impacted wisdom teeth is covered under the Evonik Medical Plan; and
- Services or supplies ordered before coverage commences, or received (installed) after coverage ends, except that of a prosthetic device, crown or root canal therapy if the applicable installment or the treatment is finished within 31 days after a Covered Person's termination of coverage.

DELTA DENTAL OF PA OPTION

This section applies only to fully insured Delta Dental of PA dental coverage option under the Plan. The Delta Dental of PA coverage option is only offered in Horsham, PA or Deer Park, Texas to Oil Additives employees, LTD Participants and Oil Additives Pre 65 Retirees who retired before January 1, 2017

For detailed information on benefits available through the Delta Dental of PA dental option, you should refer to certificate of coverage provided to you by your insurance provider. The certificate of coverage, together with this document, constitutes the SPD for the insured Delta Dental of PA dental coverage option. Except as specifically provided in this document, in the case of a conflict between the governing documents for the Delta Dental of PA option with respect to benefits and coverage limitations, the insurance contract and certificate of coverage will govern first (to the extent they do not conflict with applicable state or federal law), the Program document will govern second, and this document will govern last.

For specific information about the Delta Dental of PA coverage option, you should contact:

Delta Dental of PA
One Delta Drive
Mechanicsburg, PA 17055
1-800-932-0783

CLAIM AND APPEAL PROCEDURES

This portion of the SPD explains how to file a claim for benefits under the self-insured Aetna, Blue Cross Blue Shield of Alabama, and MetLife coverage options offered under the Plan. For information on the claims and appeals procedures for the insured Delta Dental of PA dental coverage option under the Plan, you should refer to the certificate of coverage prepared by your insurance provider and the *CLAIM AND APPEAL PROCEDURES*. *Special Claim* Procedures for Insured Coverage Options Section below.

Either a Covered Person or his or her authorized representative may file claims for benefits under the Plan and act as the claimant. In the case of an Urgent Care Claim, a health care professional with knowledge of the Covered Person's condition may always act as the Covered Person's authorized representative. For non-Urgent Care Claims, you must designate someone as your authorized representative by writing to the Claims Administrator. If you wish to designate someone as your authorized representative, you must contact your Claims Administrator to obtain an authorized representative form and complete the form as instructed. Assignment of your benefit to the Physician or other health care provider does not constitute a designation of an authorized representative for claims and appeals purposes. If a person is not properly designated as your authorized representative, the Claims Administrator will not be able to deal with him or her in connection with the exercise of your rights under the Plan. All communications from the Claims Administrator will be directed to the Covered Person claimant or his or her authorized representative.

Routine requests for information regarding your benefits under the Plan and other similar inquiries will not be considered benefit "claims" that require processing under the Plan's claims and appeals procedures (as described in this section) or ERISA. If you wish to make a claim for Plan benefits in accordance with your rights under ERISA, you must do so in writing to the Claims Administrator.

Filing a Claim for Aetna DPO, Aetna DMO and BCBS of AL PPO

You do not need to file claims for treatment provided by a Preferred Care Provider. If you use a non-Preferred Care Provider, you will need to file an itemized written claim for the payment of Covered Dental Expenses, using the Claims Administrator's claim form. Claim forms can be found on the Claims Administrator's website or by calling the Claims Administrator directly. A claim for benefits is treated as filed on the date it is received by the Claims Administrator. A Covered Person must comply with these procedures and provide the specified information in order for the claim to be considered filed with the Claims Administrator. A separate claim form must be filed for each Covered Person. Contact your dental carrier directly to obtain a claim form.

All claims must be received within 90 days from the date of service to be eligible for coverage under the Plan. All claims should be sent to the following address:

CLAIM AND APPEAL PROCEDURES

Covered Persons enrolled in the Aetna DPO or Aetna DMO dental option:
Aetna Dental
P.O. Box 14094
Lexington, KY 40512
1-877-238-6200

Covered Persons enrolled in the Blue Cross and Blue Shield of Alabama PPO dental option:
Blue Cross and Blue Shield of Alabama
P.O. Box 995
Birmingham, AL 35298
1-800-292-8868

Filing a Claim for MetLife Basic Core and Premium Option

MetLife Basic Core and Premium Option
You do not need to file claims for treatment provided by a PDP. If you do not use a PDP, you will need to file an itemized written claim for the payment of Covered Dental Expenses, using your Claims Administrator's claim form. A claim for benefits is treated as filed on the date it is received by the Claims Administrator. A Covered Person must comply with these procedures and provide the specified information in order for the claim to be considered filed with the Claims Administrator. You will receive an explanation of benefits from the Claims Administrator. A separate claim form must be filed for each Covered Person.

All claims must be received within one year from the date of service to be eligible for coverage under the Plan. All claims must be received within 90 days after the date of termination for all Covered Persons. All claims should be sent to the following address.

Employees and LTD Participants enrolled in the MetLife Basic Core or Premium dental option:
Metropolitan Life Company
Dental Claims
P.O. Box 14093
Lexington, KY 40512-4093
1-800-942-0805

CLAIM AND APPEAL PROCEDURES

Coordination with Health Care Flexible Spending Account and Limited Purpose Spending Account.

An Employee who is enrolled in the health care flexible spending account or the limited purpose spending account option under the Evonik Corporation Flexible Spending Account Plan may be eligible for reimbursement through that plan for expenses not covered by this Plan. Reimbursement for orthodontic expenses under the PayFlex Health Care Flexible Spending Account can only be reimbursed as services are incurred. Approximately one third of the total cost can be reimbursed up front, as it can be attributed to the molds, application of appliances, etc. After that, reimbursement can be made in monthly payments, throughout the duration of the treatment plan as services are incurred. Refer to the Evonik Corporation Flexible Spending Account Plan summary plan description for more information.

If a submitted claim is denied (either in whole or in part), you will receive written notice of the Claims Administrator's Adverse Benefit Determination within the applicable time period described below, based on the date the Claims Administrator received the claim. The response period that applies and the type of response (oral or written) depends on the type of claim, *i.e.*, a Post-Service Claim, a Pre-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim.

If Your Claim is Denied or Partially Denied

If a submitted claim is denied (either in whole or in part), you will receive written notice of the Claims Administrator's Adverse Benefit Determination within 30 days after receipt of the claim, unless the Claims Administrator:

- determines that an extension of up to 15 days is necessary due to matters beyond the control of the Claims Administrator, and
- notifies you during the initial 30-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to make a decision.

CLAIM AND APPEAL PROCEDURES

If you failed to provide sufficient information to decide the claim, the extension notice will identify the needed information. You will have 45 days after the receipt of the extension notice to provide the Claims Administrator with the specified information. The time in which the Claims Administrator will decide the claim will be tolled pending receipt of the requested information.

If there is an Adverse Benefit Determination on your claim, the Claims Administrator will provide written notification, which may be in the form of an explanation of benefits that includes the following:

- the specific reason or reasons for the Adverse Benefit Determination;
- specific reference to pertinent Plan provisions on which the Adverse Benefit Determination was based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary;
- appropriate information as to the steps to be taken if you wish to appeal an Adverse Benefit Determination, including any applicable time limits;
- a statement of your right to bring a civil action under ERISA Section 502(a) once the Plan's claims and appeals procedures (as described in this SPD) have been exhausted;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request;
- if the Adverse Benefit Determination is based on a medically necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- a statement that the identity of any medical or vocational experts whose advise the Claims Administrator obtained in connection with the Adverse Benefit Determination will be provided upon request, regardless of whether the advice was relied upon in making the Adverse Benefit Determination.

CLAIM AND APPEAL PROCEDURES

Appealing a Denied Claim

You may file an appeal if an Adverse Benefit Determination has been rendered on you claim.

To assist you in deciding whether to appeal an Adverse Benefit Determination or in preparing an appeal, you will be provided, upon written request to the Claims Administrator and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. You must appeal an Adverse Benefit Determination in writing and submit it to the appropriate Claims Administrator.

How to File an Appeal

An appeal of an Adverse Benefit Determination must be made within **180 days** after you receive notification of the Claims Administrator's Adverse Benefit Determination.

You must submit any appeal of an Adverse Benefit Determination to the applicable Claims Administrator at the below address:

If you are enrolled in the Aetna DPO or Aetna DMO dental option:
Aetna Dental
P.O. Box 14094
Lexington, KY 40512
1-877-238-6200

If you are enrolled in the Blue Cross and Blue Shield of Alabama PPO dental option:
Blue Cross and Blue Shield of Alabama
P.O. Box 995
Birmingham, AL 35298
1-800-292-8868

If you are enrolled in the MetLife Basic Core or Premium option:
Metropolitan Life Company
Dental Claims
P.O. Box 14093
Lexington, KY 40512-4093
1-800-942-0805

CLAIM AND APPEAL PROCEDURES

As part of the appeal, you may send the Claims Administrator a written statement of the issues, written comments, documents, records, or other information relating to the claim.

Decisions on Appeal

There are two levels of appeal available under the Plan if you are unhappy with a claim decision.

First Level of Appeal. You must appeal an Adverse Benefit Determination within **180 days** of receipt of a denial notice. The first level appeal will be reviewed and decided by the Claims Administrator within 30 days of receipt of your appeal request. On review, the Claims Administrator will take into account all comments, documents, records, and other information you submitted, without regard to whether such information was considered in the initial determination. No deference will be given to the previous Adverse Benefit Determination. You will receive written notice of the Claims Administrator's decision.

Second Level of Appeal. If your first level appeal is denied, you may submit the claim for a second level appeal. You must request a second level appeal within **60 days** from receipt of the Adverse Benefit Determination on the first level appeal. The second level appeal will be decided within 30 days of receipt by the Claims Administrator.

The Claims Administrator will review the second level appeal. On review of the second level of appeal, the Claims Administrator will take into account all comments, documents, records, and other information you submitted, without regard to whether such information was considered in the initial determination or the first level of appeal. No deference will be given to the previous Adverse Benefit Determinations.

Notice of Decision on Appeal

If the Claims Administrator renders an Adverse Benefit Determination on the first or second appeal, the Claims Administrator will provide written notification that includes the following:

- the specific reason or reasons for the Adverse Benefit Determination;
- specific reference to pertinent Plan provisions on which the Adverse Benefit Determination was based;
- a statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- a statement of your right to bring a civil action under ERISA Section 502(a) once the Plan's claims and appeals procedures (as described in this SPD) have been exhausted;

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- if the Adverse Benefit Determination is based on a medically necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Scope of Review of Appealed Claims

The Plan Administrator has delegated to the Claims Administrators the discretionary responsibility and authority to determine claims under the Plan and to construe, interpret, and administer the Plan. During the review of an Adverse Benefit Determination on first and second appeal, the Claims Administrator will:

- Take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether such information was submitted or considered in a prior determination of the claim;
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan and Program documents; and
- Follow reasonable procedures to ensure that the applicable Plan and Program provisions are applied to your claim in a manner consistent with how such provisions have been applied to other similarly situated Covered Persons.

If Your Claim is Denied on Second Appeal

No action at law or in equity may be brought to recover under this Plan until the claims and appeals procedures, as described above, have been exhausted, and the benefits requested in the final appeal have been denied in whole or in part. **Any legal action brought against the Plan must be brought by the earliest of the following: (i) 90 days from the date of the final Adverse Benefit Determination after all appeals and reviews have been utilized and exhausted, (ii) three years after the date that the service or treatment at issue in the legal action was provided by a Physician, Hospital, or other health care provider, or (iii) the statutory deadline for filing a claim or lawsuit with respect to the Plan benefits at issue in the judicial proceeding as determined by applying the most analogous statute of limitations for the State of Delaware. If you do not file a legal action within this time period, you lose any rights to bring such an action against the Plan or its fiduciaries.** If you decide to pursue any legal action relating to your claim, the evidence that you may present in your case will be strictly limited to the documents, information, and other

evidence timely presented to the designated Claims Administrator, the Plan Administrator, and any external reviewer, if applicable as described above.

CLAIM AND APPEAL PROCEDURES

Special Claims Procedures for Insured Coverage Options

If you are enrolled in the insured Delta Dental of PA coverage option, the insurance provider is the Claims Administrator. The insurance provider will require that you follow certain internal appeal procedures (sometimes called grievance procedures or determination procedures) if you request dental treatment and your request is denied by the provider. You must follow these internal procedures in order to receive a full and fair review from the insurance provider. Note that all claims and appeals requirements established by the insurance provider must meet minimum standards under ERISA.

These Insured Dental Provider's Grievance Procedures Do Not Apply

When you exhaust the internal grievance procedures, some insured dental providers might have additional appeal rules that require binding arbitration or that limit your rights to go to court. Some insured dental providers might require that you submit your appeal to an "independent reviewer." These appeal rules do not always comply with ERISA. The following is a list of insured dental provider grievance procedure appeal rules that do not comply with ERISA. If you have reached a level of appeal that requires you to do one of the following, you should know that the procedures described in this section and the rules in the *Statement of ERISA Rights* section below will override the insured dental provider requirements (*i.e.*, this section governs in the event of a conflict between this document and the Delta Dental of PA certificate of coverage).

- No insured dental provider may require you to submit to binding arbitration or to binding mediation. If your certificate of coverage advises that you must submit to binding arbitration or binding mediation after you exhaust the insured dental provider's internal grievance procedure, you should know this rule does not comply with ERISA. If you voluntarily agree to binding arbitration or binding mediation, you may be giving up the right you have under ERISA to sue the insured dental provider in federal court. If you have a serious claim, you should check with legal counsel before you submit to binding arbitration or binding mediation with the insured dental provider.
- No insured dental provider can make the statement that, by virtue of becoming covered under an insured dental coverage option, you have agreed to give up any rights you have to sue, including any "constitutional rights" or any "ERISA rights."
- No insured dental provider may require you to pay for any internal grievance or appeal procedure. If the insured dental provider certificate of coverage tells you that you must pay for part or all of any type of fees involved in a grievance procedure, arbitration, mediation, or any legal fees, you should know that ERISA does not allow this type of charge.

CLAIM AND APPEAL PROCEDURES

- No insured dental provider may require you to undergo more than two levels of appeal following the initial denial of your claim for benefits. If your insured dental provider has additional levels of appeals, you may choose to follow those optional appeal procedures rather than to sue the insured dental provider in federal court under ERISA. However, by submitting to these additional appeals procedures, you may negatively affect your ability to sue the insured dental provider under ERISA (for example, if the insured dental provider is required under state law to provide additional levels of review, then the statute of limitations on your claim may continue to run while you pursue your appeal with the insured provider). If you have a serious claim, you should check with legal counsel before you choose to pursue optional insured dental provider appeals rather than taking your case directly to federal court.
- No insured dental provider may require that you accept the decision of an independent reviewer on a benefit denial appeal. The insured dental provider may be required to submit your claim to an independent reviewer under state law, and you can agree to abide by the independent reviewer's decision if you want to do so. However, before you agree ahead of time to accept the decision of an independent reviewer, make certain you read the procedures described in the claims and appeals procedures sections above (applicable to the self-insured coverage options) and the rules in the *Statement of ERISA Rights* section below, first, because you may be giving up your right to sue for the benefit under ERISA.
- If you find that you want to exercise your rights as described in the *Statement of ERISA Rights* section below, you should not wait too long after the insurance provider gives you its final decision when you go through the grievance procedure. This is because, under the Plan, you have 90 days following your receipt of a final decision after completing the grievance process to take legal action, as described in the *Statement of ERISA Rights* section.

All insured dental providers are subject to state regulation. If you have a complaint about an insured dental provider you can contact the state insurance department listed in your insured dental certificate of coverage. Remember, even when you contact the state insurance department with a complaint, you still have ERISA rights as explained in the *Statement of ERISA Rights* section below.

FINAL AND BINDING DECISIONS

The Plan Administrator has sole and complete discretionary authority to determine questions relating to eligibility for participation in the Plan and reserves the right to amend or terminate the Plan at any time. The Plan Administrator has delegated responsibility for reviewing and deciding claims for benefits to the Claims Administrators. Respective decisions by the Claims Administrators and the Plan Administrator will be conclusive and binding on all parties and not subject to further review.

COORDINATION OF BENEFITS

Aetna, Blue Cross and Blue Shield of Alabama and MetLife Coverage Options

Coordination of benefits rules under the insured Delta Dental of PA coverage option are explained in the certificate of coverage.

The Plan coordinates benefits from all group plans and certain insurance arrangements covering a Covered Person to prevent duplication of dental benefit payments. The Plan's coordination of benefits rules set out the order for payment of covered charges when two or more plans are potentially responsible for Covered Dental Expenses. When a Covered Person is covered by the Plan and another plan, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the coordination of benefits rules will pay as if there were no other plan involved. This Plan has a non-duplication of benefits provision. Under coordination of benefits, the total benefits paid by all plans combined will not exceed 100% of the amount that would have been paid by this Plan if you had no other coverage. When the other plan does not have a non-duplication or coordination of benefits provision, it will be the primary plan. If both plans have non-duplication or coordination of benefits provisions, the payment order will be decided in the order described below.

Other Plans

This Plan coordinates payment of dental benefits with certain other plans of a Covered Person. For purposes of coordination of benefits, the term "plan" means this Plan and any one of the following plans or insurance arrangements:

- group or group-type plans, including franchise or blanket benefit plans;
- group practice and other group prepayment plans;
- other plans required or provided by law (this does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination); and
- No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law. Order of Benefit Determination

For purposes of coordination of benefits, the rules establishing the order of benefit determination are as follows:

- A plan that covers a person other than as a dependent will be primary to a plan that covers such person as a dependent.
- A plan that covers a person as a dependent of a Covered Person whose date of birth occurs earlier in a Calendar Year will be primary to a plan that covers such person as a dependent of Covered Person whose date of birth occurs later in a Calendar Year (only month and day of birth, not year, will be reviewed in this case).

COORDINATION OF BENEFITS

Aetna, Blue Cross and Blue Shield of Alabama and MetLife Coverage Options

- In the case of dependent child whose parents are separated or divorced:
  - When the parent with custody of the child has not remarried, the plan that covers the child as a dependent of the parent with custody will be primary to the plan that covers the child as a dependent of the parent without custody; and
  - When the parent with custody of the child has remarried, the plan that covers the child as a dependent of the parent with custody will be primary to the plan that covers the child as a stepparent, and the plan that covers the child as a dependent of the stepparent will be primary to the plan that covers the child as a dependent of the parent without custody. However, if there is a court decree which establishes financial responsibility for the dental expenses of the child, the plan that covers the child as a dependent of the parent with such responsibility will be primary to any other plan that covers the child as a dependent.
- The plan that covers the person as a laid-off Covered Person, or as a dependent of such a Covered Person will be secondary to any plan that covers such person as Covered Person or as a dependent of such a Covered Person,
- When the rules stated above do not determine an order of benefit determination, the plan that has covered a person for the longer period of time will be primary.

Payment to Other Organizations

Whenever payments that should have been made under this Plan in accordance with these coordination of benefits provisions have been made under any other plans, this Plan may pay to the other plan (or any entity making such other payments) any amounts the Claims Administrator determines to be warranted in order to satisfy the intent of these provisions. Amounts paid to the other plan will be deemed to be benefits paid under this Plan, and to the extent of such payments, this Plan will be fully discharged from liability.

Reimbursement

If at any time the amount of benefits provided by this Plan exceeds the maximum payment necessary to satisfy the intent of these coordination of benefits provisions, this Plan may recover any excess payments from any one or more of the following: (i) the Covered Person; (ii) if the person is a Dependent, the Dependent and the Covered Person for whom the person is a Dependent; (iii) any other plan or person that has received payment; and (iv) any other plan that should have made the payment.

COORDINATION OF BENEFITS

Aetna, Blue Cross and Blue Shield of Alabama and MetLife Coverage Options

Automobile Limitations

When dental payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan will always be considered the secondary carrier, regardless of the individual's election under personal injury protection coverage with the auto carrier. Benefits will be determined under these coordination of benefits rules, before application of any subrogation rules.

Third Party Liability

When dental payments are available due to the liability of a third party, the Plan will pay excess benefits only, without reimbursement for deductibles. This Plan will always be considered the secondary carrier regardless of the Covered Persons intent to pursue reimbursement from the third party. Benefits will be considered under the provisions of coordination of benefits prior to the provisions of subrogation.

Other Limitations

This Plan will always be considered the secondary plan with respect to fault or personal injury protection, catastrophic funds mandated by motor vehicle or other state law, uninsured motorist, motor vehicle medical reimbursement, (regardless whether it is purchased by the Covered Person), homeowner's insurance, premises insurance, or other similar coverage.

Right to Receive and Release Necessary Information

In order to decide if the Plan's coordination of benefits rules (or any other benefit plan's coordination of benefits rules) applies to a claim, the Plan Administrator or the Claims Administrator (without the consent of or notice to any person) has the right to:

- release to any person, insurance company, or organization, the necessary claim information; and
- receive from any person, insurance company, or organization, the necessary claim information.

You must cooperate with the Claims Administrator and Plan Administrator to comply with the Plan's coordination of benefits rules. This includes, but is not limited to, supplying any information needed to coordinate benefits and/or executing any necessary forms and/or documents.

COORDINATION OF BENEFITS

Aetna, Blue Cross and Blue Shield of Alabama and MetLife Coverage Options

Subrogation and Right of Reimbursement

This section applies to the self-insured dental coverage options. Subrogation and reimbursement rules under the insured Delta Dental of PA coverage option are explained in the certificate of coverage.

This Plan is not intended to provide you with benefits greater than those benefits described in this SPD. Therefore, if you are entitled to payment of your dental expenses by another person, plan, or entity, whether you request payment or not, this Plan has the right to reduce its payments accordingly so that the Plan does not pay for amounts you would otherwise owe for your share Covered Dental Expenses if the Plan was the only other payer. If you have a right against any other person, firm, or organization for an injury or sickness, or any related complications, the Plan has the right to subrogate all benefits considered, or that will be considered, by the Plan because of the sickness or injury or any related complications. The Plan has the right to recover the cost of any benefits paid for expenses that are the responsibility or liability of a third party.

If benefits are paid under the Plan and you later obtain a recovery, you are obligated under the terms of this Plan to reimburse the Plan for the benefits paid out of the recovery amount. The Plan will be reimbursed in full for benefits paid, regardless of whether you have been "made whole" or fully compensated for damages by any responsible person or third party alleged to be legally responsible to you, and regardless of whether dental expenses are itemized in a payment or award. Such recovery will be available from any liable person (third party), including but not limited to:

- the persons and entities, either individually or collectively, causing an injury, sickness, or other loss for which this Plan had or may provide benefits;
- third party insurance;
- no-fault or personal injury protection insurance;
- financial responsibility or catastrophe funds mandated by motor vehicle or other state law;
- uninsured or motorist under-insured insurance;
- motor vehicle reimbursement insurance, regardless of whether or not it is purchased by you or another Covered Person; and
- homeowner's insurance and other premises insurance, including reimbursement coverage.

COORDINATION OF BENEFITS

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Reimbursement due the Plan will not be subject to or limited by any proration formula that takes into account the relationship between the amount of damages claimed by you and the amount of recovery you actually received, whether by settlement, judgment, insurance proceeds, or in any other manner, nor will it be subject to or limited by any reduction of any recovery of payment due to your or any third party's fault or negligence.

You must cooperate with and assist the Claims Administrator and Plan Administrator to protect the Plan's legal rights under these subrogation provisions. The Plan maintains both a right of reimbursement and a separate right of subrogation. You must not do anything to prejudice the Plan's rights under this provision, either before or after the need for services or benefits from this Plan. You are obligated to immediately inform the Claims Administrator of any sickness or injury for which a claim for damages may be made against any third party. You must acknowledge that the subrogation right and reimbursement right of the Plan will be considered the first priority claim against any third party, to be paid on a first-dollar basis before any other claims which may exist are paid, including claims by you or on your behalf for general damages.

The payment of benefits under this Plan is conditioned upon the Plan's right of reimbursement from the proceeds of any recovery received by or payable to you, whether by settlement, judgment, insurance proceeds, or otherwise. The Plan may, at its discretion, take such action as may be necessary and appropriate to preserve its rights, including placing a lien against any third party recovery to the extent of the benefits paid by the Plan related to the sickness or injury, bringing suit on your behalf, or intervening in any lawsuit involving you related to the sickness or injury. The Plan may, at its discretion, require the assignment of your right of recovery, up to the extent of benefits provided under the Plan. The Plan may initiate any suit against you or your legal representative to enforce the subrogation and reimbursement terms of this Plan. Any proceeds collected, held, or received by you, your legal representative, or any other party to whom such proceeds may be paid in connection with a settlement of, or judgment relating to, any claim that arises from the same event to which payment by the Plan is related, are constructively held in trust for the benefit of the Plan and for satisfaction of the Plan's subrogation right and/or reimbursement right. Once settlement is reached, the Plan Administrator or Claims Administrator will require copies of all court documents and/or settlement agreements. Benefits will then be adjudicated according to the rules of coordination of benefits.

COORDINATION OF BENEFITS

Aetna, Blue Cross and Blue Shield of Alabama and MetLife Coverage Options

Once the Claims Administrator determines that third party liability may be involved with a claim, if applicable, you will be asked to sign a subrogation and reimbursement agreement, protecting the Plan against any loss where other parties may be responsible. The Claims Administrator must have received the signed subrogation agreement before any claims may be considered for payment. If a signed subrogation agreement is not received within 90-days after being provided by the Claims Administrator, the claims will be denied. A violation of the subrogation and reimbursement agreement is considered a violation of the terms of the Plan.

If you directly receive payment from or on behalf of any third party, you are required to immediately reimburse the Plan on a first dollar basis the full amount of benefits paid by the Plan, up to the aggregate amount recovered from or on behalf of each third party. Except to the extent permitted by the Plan Administrator pursuant to nondiscriminatory rules established by the Plan Administrator in its discretion, the Plan will not pay attorney fees or costs associated with your claim or lawsuit unless it consents in writing to make such payment. To the extent permitted by applicable law, amounts due the Plan under this section may be applied against any other present or future benefits (and thereby reduce such benefits) payable under this Plan to or on behalf of you, the Covered Person or his or her other covered Dependents, regardless of whether such benefits are related to the subject sickness or injury. If you do not reimburse the Plan under this section within seven days of receipt of payment from or on behalf of a third party, interest at the rate of 1½% per month will be charged on the unreimbursed amount due the Plan.

IMPORTANT NOTICE FOR NON-ENGLISH SPEAKING COVERED PERSONS

Para Empleados Que No Hablan Ingles

Este documento contiene un resumen en ingles de los derechos y beneficios que le corresponden bajo el plan de seguro de accidente grupal creado y mantenido por su empresa. Si tiene alguna pregunta acerca de la información contenida en el documento, comuníquese con el Administrador para obtener ayuda. La dirección del Administrador es:

Evonik Corporation Administrative Committee
c/o Evonik Corporation
299 Jefferson Road
Parsippany, NJ 07054-0677

DEFINED TERMS

The following terms have special meanings and, when used in this SPD, will be capitalized. These defined terms apply only to the extent used in this SPD. These defined terms do not apply to the fully-insured Delta Dental of PA coverage option.

Adverse Benefit Determination means a claim submitted which is denied (either in whole or in part) by the Claims Administrator.

Claims Administrator means the entity identified in the *General Plan Information* section.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Administrator means the entity identified in the *General Plan Information* section.

Company means Evonik Corporation.

Coinsurance means the percentage of the charges you pay for certain covered services when you use a Dentist.

Covered Dental Expenses means services or supplies for which a benefit is payable under the Plan.

Covered Person means an Employee, an LTD Participant, [Retiree, if applicable] or a Dependent of those who is covered under this Plan.

Deductible means the amount of charges for covered services that each Covered Person must satisfy each Calendar Year before the Plan begins to pay benefits.

Dentist means a person licensed by law to practice Dentistry. A type of dental service which is performed or prescribed by a doctor will be considered as if it were performed or prescribed by a Dentist.

Dependent means a Covered Person's Spouse and eligible child(ren), as set forth in the *Eligibility and Enrollment* section above.

Directory is a listing of all Preferred Care Providers or Preferred Dentists with respect to the applicable dental coverage option. A free copy of the Directory for your dental coverage option is available upon request by contacting the appropriate Claims Administrator.

DEFINED TERMS

DMO ® — Dental Maintenance Organization means that the DMO option includes both a network component and a non-network component. Under the Aetna DMO option, an Employee and LTD Participant can receive benefits at a lower cost under the Plan by using Participating Dentists. DMO is a service mark of Aetna, Inc., registered in the U.S. Patent and Trademark Office.

Employee means a person employed by the Employer. An individual who is classified by an Employer as an independent contractor or other non-employee will not be considered an Employee under the Plan, regardless of whether the individual is deemed by a government agency or a court to be a common law employee of the Employer.

Employer means the Company and each affiliate of the Company which is participating in the Plan. An affiliate means a legal entity or division of a legal entity that is under common control with the Company.

ERISA means the Employee Retirement Income Security Act of 1974, as amended, and its applicable regulations. Reference to any section or subsection of ERISA includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

FMLA means the federal Family and Medical Leave Act of 1993 and its applicable regulations, as amended. Reference to any section or subsection of FMLA includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

FMLA Leave means a leave of absence that the Employer is required to extend to an Employee under the provisions of the Family and Medical Leave Act of 1993.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and its applicable regulations.

Late Enrollee means an Employee who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a special enrollment period.

Lifetime means during the Lifetime of the Covered Person while covered under this Plan.

LTD Participant means a former Employee who remains a Covered Person for purposes of the Plan because he or she is receiving long-term disability benefits from the Evonik **LTD** plan. **LTD** means long-term disability.

MetLife PDP means a preferred Dentist program that allows Cover Persons to select a Dentist at the time of treatment. Under the MetLife PDP (Preferred Dentist Program), you do not have to select a primary care Dentist nor do you need referrals for specialty

care. PDP Dentists agree to accept negotiated rates as payment in full for covered services.

Negotiated Charge means the maximum charge a Preferred Care Provider or Preferred Dentist has agreed to accept for any service or supply for the purpose of the benefits under the Plan.

Plan means the dental benefits provided under the Evonik Corporation Dental Plan, which is a welfare benefits plan for certain eligible Covered Persons of Evonik Corporation and the other participating Employers as described herein.

Plan Administrator means the Administrative Committee of Evonik Corporation, which has the authority to administer the Plan.

Plan Sponsor means the Evonik Corporation, which directs the establishment of the Plan and the Program, appoints the administrator of the Plan and funds the Plan on behalf of Covered Persons.

Plan Year means each 12 consecutive month period beginning on January 1 and ending on the next following December 31.

Post-Service Claim means a claim that is not a Pre-Service Claim. It is a claim for benefits submitted after the service or supply has been furnished.

Preferred Care Provider means a dental health care provider that has contracted to furnish services or supplies for a Negotiated Charge; but only if the provider is, included in the Aetna Directory as a Preferred Care Provider for the service or supply involved for Covered Persons under this Plan.

Preferred Dental Schedule means the maximum charge a Preferred Dentist has agreed to accept for any service or supply for the purpose of the benefits under the Plan.

Preferred Dentist means a Dentist who has an agreement with Blue Cross and Blue Shield of Alabama to provide dental services to Covered Persons under the Preferred Dentist Program.

Primary Care Dentist means a Dentist who has entered into an agreement to provide in-network dental care to Covered Persons and who has agreed to accept a Negotiated Charge for those services or supplies.

Protected Health Information means health information that could identify an individual. It is created or received by a health care provider, health plan, employer, or insurer, and either relates to the physical or mental health of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual. Protected Health Information can be in an electronic, paper, or oral format.

DEFINED TERMS

Qualified Medical Child Support Order (**QMCSO)** means a judgment, decree or court order which provides for group health plan coverage for a Dependent child of a Covered Person. A QMCSO must comply with Section 609 of ERISA and be subject to procedures established by the Plan Administrator. The Company has established guidelines for processing a QMCSO. All correspondence and questions, including a request for a free copy of these guidelines should be directed to the Plan Administrator. Subject to a QMCSO, Covered Persons election in the Plan may be changed by the Plan Administrator to provide coverage to a Dependent child in accordance with the terms of a QMCSO. You must make written request for such coverage. Coverage for the Dependent child will become effective on the date specified by the Plan Administrator.

Retiree means a former Employee as defined under the Eligibility section of the Summary Plan Description for the Evonik Corporation Consolidated Retiree Welfare Benefits Program.

Spouse means the Covered Person's legal partner in marriage to whom the Covered Person is not legally separated or divorced. Spouse includes a same-sex spouse to whom the Covered Person is legally married. Spouse does not include Covered Person's registered domestic partner, civil union partner, or other similar relationships recognized under state law. For the insured Delta Dental plan, Spouse means the Covered Person's spouse as defined in the applicable certificate of coverage or summary of benefits booklet; however, the Company does not contribute to the cost of coverage for a domestic partner, civil union partner, or other similar spouse equivalent that may be eligible for coverage under the terms of the insured HMO.

STD Benefit - Benefits provided under the Evonik Corporation Short Term Disability Procedure ("STD Procedures") to individuals who meet the STD procedures' eligibility requirements.

STD Procedure - The Evonik Short Term Disability Procedure

Usual and Reasonable Charge means a charge for dental care which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider complications or unusual circumstances that require more time, skill or experience. The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge. The Claims Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Waiting Period means the number of days after the first day of eligibility as a Covered Person that must pass before you are eligible to enroll and participate in this Plan. However, see the Exclusions and Limitations sections where a service provided to a

DEFINED TERMS

Covered Person age 5 or more, during the first 31 days the person is eligible for coverage, may not be considered a Covered Dental Expense**.**