2022 Annual Enrollment Information for Cyro Pre-65 Retirees

Summary of Material Modification

EVONIK
Leading Beyond Chemistry

What's Inside

Welcome to 2022 Annual Enrollment!

Annual Enrollment is your once-a-year opportunity to review your Evonik Benefits Program options and choose the benefits that best meet your needs and those of your family. The Annual Enrollment period for 2022 Evonik benefits begins on October 18, 2021 and ends on October 29, 2021.

What's New for 2022

- Contribution rates for 2022 will remain unchanged, unless your or your dependent coverage changes.
- BCBS benefit plan designs will also remain unchanged, with no increases to copays, coinsurance, deductibles and out-of-pocket costs.
- Health Savings Account (HSA) annual contribution limits will increase, allowing you to save more to pay for eligible health care expenses.
- You may receive a new Medical ID card, even if you enrolled in 2021 Evonik Medical Plan coverage and keep the same coverage for 2022, given a provision of the federal No Surprises Act, which protects consumers from receiving surprise medical bills resulting from gaps in coverage for emergency service and certain services provided by out-of-network clinicians and in-network facilities.
- We will be conducting a Dependent Eligibility Audit early in 2022 to ensure all enrolled dependents are eligible for coverage. We strongly encourage you to review the dependent eligibility rules on page 3 before doing so.

Consider Your Benefit Needs for 2022

- Review your medical expenses for 2022. This will give you an idea of your routine needs and costs. Do you usually have large and/or frequent medical expenses during the year, or are your medical expenses generally limited to routine check-ups and an occasional office visit?
- Think about how much you can afford to pay out-of-pocket before the Medical Plan pays your expenses. Compare the premium and potential out-of-pocket expenses costs for each option.
- Look to see if you have more cost-effective coverage available through another plan, such as through your spouse's plan. If so, review the costs of each plan. This is particularly important for deciding which plan you should enroll your children in. Because benefit plans coordinate benefit payments, being covered under more than one plan may not give you better coverage.

Making Benefit Changes for 2022

It's a good idea to closely review your benefits needs each year. We encourage you to consider the benefits you used in 2021 and estimate how these needs may change in 2022.

You **are not** required to actively enroll for 2022 Evonik health benefits. If you decide not to make any changes, your 2021 benefits will carry forward to next year at 2022 contribution rates.

Be Sure Your Dependents Are Eligible for Coverage

Your dependents must meet Evonik's eligibility requirements to be covered by Evonik benefits. The Company reserves the right to verify dependent status periodically and may request proof of eligibility from you at any time.

You may enroll eligible dependents for coverage. Under the Evonik Retiree Medical Plan, your eligible dependents are your:

- Legal partner in marriage who was your legal partner at the time you retired from Evonik from whom you are not legally separated or divorced (legal partner includes a same-sex spouse to whom you are legally married and does not include your registered domestic partner, civil union partner or other similar relationships recognized under state law); and
- Eligible children from birth until 26 years of age, including:
  - Biological children, stepchildren, adopted children, foster children, children for which you have legal guardianship and children who are the subject of a Qualified Medical Court Support Order (QMCSO).
  - Children until age 26, regardless of a child's residency, financial dependence, student status, employment or other factors due to the Affordable Care Act.
  - Unmarried dependent child age 26 or older, if the child cannot support himself or herself because of a physical or mental disability and is primarily dependent upon you for support. You are required to submit proof of the disability within thirty-one (31) days after the child's 26th birthday.

2022 Dependent Eligibility Audit

Evonik will be conducting a dependent eligibility audit in 2022, and coverage will end for any dependents/spouses who do not meet the Benefits Program's eligibility requirements. Dependent eligibility audits are performed to help prevent the millions of dollars in extra medical costs that may result from people mistakenly or deliberately enrolling ineligible dependents for coverage in error, or enrolled dependents becoming ineligible for age or other reasons.

Be sure that dependents you enroll for 2022 coverage meet the requirements described above. Any misrepresentation of dependent information will be considered a deliberate falsification of Company records. You may also be held financially responsible to repay any claims the plan paid on your behalf for the improperly covered person.

Retiree Benefits Administration Provided by Mercer

Mercer Health & Benefits Administration, LLC (Mercer) is the administrator for Evonik's retiree benefits. Mercer provides a comprehensive customer service experience for our retirees.

Mercer's trained benefits specialists are knowledgeable about Evonik's retiree benefits and retiree benefit needs. In addition, Mercer's advanced technology capabilities give you access and information so that you can make informed benefit decisions when it truly matters most.

Benefit Resources

You have 24/7 access to Mercer's retiree health insurance benefits website **EvonikRetireeBenefits.com.** The **EvonikRetireeBenefits.com** website provides convenient access to a variety of helpful online resources, including:

- Benefits Enrollment
- Information about Medical, Prescription Drug, and other coverages as applicable
- Annual Benefits Enrollment news
- Account access details (for anyone currently enrolled)
- Annual Summary of Benefits & Coverage (SBC)
- Sign up for electronic funds transfer to pay your retiree contributions

When you call the Evonik Retiree Service Center at Mercer at **1-855-684-6628.** The Retiree Service Center will be available Monday – Friday from 8:00 am to 9:00 pm ET to assist you. You can receive assistance with the following questions:

- Retiree health insurance plan enrollment, eligibility and coverage effective date
- Retiree health billing questions and plan changes
- General retiree health and other insurance coverage information
- Enrollment material requests
- How to obtain ID cards
- Authorizing a representative or Power of Attorney
- Death notifications

How to Change Your Benefit Elections

Mercer's support, including a Retiree Service Center staffed with knowledgeable representatives, is available to you during this year's Annual Enrollment season and remain at your service year-round.

Changing your 2022 retirement benefits is easy, and we are providing you with several ways to enroll including:

- **Mail**: Complete the enclosed enrollment form and return it to Mercer in the envelope provided. Note, enrollment forms must be postmarked by **October 29th** or;
- **Online:** Online: Access our new Evonik Retiree website at **www.evonikretireebenefits.com** and click on the "Enroll Now" button for Pre-65 retirees. You will need your Mercer Certificate Number (beginning with **26019**) located on the enclosed enrollment form. If you don't have your Mercer Certificate number, call the Mercer Retiree Service Center for assistance. The Mercer representative will ask a series of privacy questions to validate your identity or;
- **Call**: Call the Mercer Retiree Service Center at **1-855-684-6628**. Mercer representatives can take your enrollment information over the telephone. The Retiree Service Center will be available Monday – Friday from 8:00 am to 9:00 pm ET to assist you.

If you elect to enroll via the website or call center, you must have your enrollment **completed by Friday October 29th.**

Mercer will process your enrollment and send your elections to BCBS who will be sending you your new medical ID cards beginning mid to late December.

Note, if you elect to decline coverage, re-enrollment into the Plan **will not be permitted** at a future date once you and/or your dependent(s) decline medical coverage under the Plan.

My Retiree Account

You can track and manage your retiree benefits with the Mercer My Account from any device including a tablet or mobile phone. On the Mercer My Account, you can:

- Review coverage(s) in which you are currently enrolled
- View current billing/payment status – if applicable
- Review your current billing information
- Arrange electronic payment (auto pay) from your bank
- Request a copy of your premium notice
- Update your personal data such as password, email address, security question and answer, phone number, address

The Mercer My Account can be accessed by clicking on the **My Account** button at **EvonikRetireeBenefits.com or visiting www.mercermyaccount.com.**

To register your "My Account" you will need the following:

- A valid email address
- Your Mercer Insurance Certificate Number - which can be found on your enrollment form included with this brochure beginning with **26019**. If you don't have your Mercer Certificate number, call the Mercer Retiree Service Center at **1-855-684-6628** for assistance. The Mercer representative will ask a series of privacy questions to validate your identity.

How do I contact the Retiree Service Center?

We have worked with Mercer to provide you with additional resources to help you with your benefits, including the retiree service center and the retiree website at **www.evonikretireebenefits.com**.

If you have questions or need additional information, do not hesitate to contact the Evonik Retiree Service Center. The dedicated retiree customer service team can be reached at **1-855-684-6628** or you can email Mercer at retiree.service@mercer.com. The Service Center will be available Monday – Friday from 8:00 am to 9:00 pm Eastern Time to assist you.

Health Advocacy

Included with your medical coverage all retirees including dependents will have access to Health Advocacy services provided by Health Advocate. Health Advocate is an independent resource for you to use to help navigate the often times complex healthcare system.

Health Advocates' Personal Health Advocates are healthcare experts with extensive experience supporting people with important medical issues and decisions, no matter how common or complex. The Personal Health Advocates are typically registered nurses supported by medical directors and benefits experts and they work on your behalf.

Health Advocate is there to help our retirees and their dependents with a wide range of issues including:

Clinical

- Answer questions about medical diagnoses and review treatment options
- Research and identify the latest, most advanced approaches to care
- Coordinate clinical services related to all aspects of medical care
- Assist with scheduling appointments at times that work for your schedule
- Help retirees prepare for doctor visits, review results

Administrative Support

- Explain your benefits and how they work
- Research and provide assistance to resolve insurance claims and medical billing issues
- Assist in finding the right in-network doctors and providers
- Facilitate any required pre-authorizations for medical services, Durable Medical Equipment and prescription drugs
- Facilitate the transfer of medical records between physicians

Health Advocate can be reached at **1-866-695-8622.** Your Health Advocate services can be accessed 24/7. Normal hours of operation are Monday - Friday from 8:00 am to 10:00 pm Eastern Time. Staff is also available for assistance after hours and on weekends.

Your 2022 Medical Plan Options

We recognize that some retirees prefer to pay more in out of pocket expenses when they use the plan and have lower contributions while others prefer to pay higher contributions but have less out of pocket expenses when they use the plan. Given these different needs, you will have a choice of three Medical Plan options for 2022:

- BCBS - Choice Plus HSA
- BCBS - Choice Plus Value HSA
- BCBS - Cyro Pre-65 Plan

* For information on how a Health Spending Accounts (HSAs) works, eligibility for an HSA, IRS annual contributions, refer to page 16 in this brochure.

Medical Plan Comparison

The comparison chart shows general coverage information for available retiree plans. Remember, as health care costs continue to increase, it is important to shop for health care services like you would for the purchase of other major goods and services. We encourage you to familiarize yourself with the cost of medical services you receive and to utilize in-network providers when possible. Maintaining a healthy lifestyle and taking advantage of preventive care services may also help to keep down your medical costs.

Take Note:

- In-network benefits are paid based on the negotiated charges with the carrier, and you'll typically pay less when you see an in-network provider.

- Out-of-network benefits are paid based on the contracted rate, as determined by the carrier, or another amount as determined under the federal No Surprise Billing Act.

- You are responsible for any costs over the contracted rate. Special rules apply for emergency care or other ancillary care as required by law.

Here is a summary of all of your 2022 Medical Options and their design highlights.

BLUE CROSS BLUE SHIELD PLANS ADMINISTERED BY BCBS OF AL						
Plan Choice	**Choice Plus HSA Pre-65 Non Medicare**		**Choice Plus Value HSA Pre-65 Non Medicare**		**Cyro Pre-65 Plan**	
Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	• Retiree Only: $1,400 • Family: $2,800	• Retiree Only $1,400 • Family: $2,800	• Retiree Only: $2,850 • Family: $5,700	• Retiree Only: $2,850 • Family: $5,700	• Retiree Only $450 • Family: $900	
Annual Out-of-Pocket Maximum *Includes Deductible*	• Retiree Only: $3,200 • Family: $4,600	• Retiree Only: $3,200 • Family: $4,600	• Retiree Only: $5,500 • Family: $11,000	• Retiree Only: $5,500 • Family: $11,000	• Retiree Only: $1,750 • Family: $3,500	
Lifetime Maximum per person	N/A	N/A	N/A	N/A	$750,000	
Preventive Care	Plan pays 100%	Plan pays 80%	Plan pays 100%	Plan pays 80%	Plan pays 100%	
Office Visits	Plan pays 70%, after ded.	Plan pays 60%, after ded.	Plan pays 70%, after ded.	Plan pays 60%, after ded.	Plan pays 80%, after ded.	
Hospital Inpatient	Plan pays 70%, after ded.	Plan pays 60%, after ded.	Plan pays 70%, after ded.	Plan pays 60%, after ded.	Plan pays 80%, after ded.	
Emergency Care*	Plan pays 70%, after ded.	Plan pays 60%, after ded.	Plan pays 70%, after ded.	Plan pays 60%, after ded.	Plan pays 80%, after ded.	
Diagnostic/X-rays	Plan pays 70%, after ded.	Plan pays 60%, after ded.	Plan pays 70%, after ded.	Plan pays 60%, after ded.	Plan pays 80%, after ded.	
Outpatient Surgery	Plan pays 70%, after ded.	Plan pays 60%, after ded.	Plan pays 70%, after ded.	Plan pays 60%, after ded.	Plan pays 80%, after ded.	

**Non emergencies have different coinsurance levels. Other benefits from non-network providers may be paid at in-network rates as required by law. In-network benefits are paid up to the negotiated rate. Due to the No Surprise Billing Act, some out-of-network providers may be paid at contracted rates. The member is responsible for any amounts above the contracted rates. For example, in some cases providers are prohibited for balance billing the participant.*

Contributions Are Not Changing

Pre-65 contributions for the medical options will not change for 2022. Please review your enrollment form within this packet for the 2022 contributions for each of the BCBS medical options. Your contribution costs and potential savings will depend on your specific medical option selected.

Express Scripts Prescription Drug Coverage

All Medical Plan options offer prescription drug coverage through Express Scripts Inc. (ESI).

The amount you pay for prescription drugs will depend on:

- The Medical Plan option you choose
- Whether you use an in-network retail pharmacy, an out-of-network retail pharmacy, Smart90 or mail order, and
- The category of drug you use – generic, non-preferred brand, or preferred brand.

Contact **Express Scripts** at **1- 877-657-2496** if you have any questions about the Express Scripts prescription drug benefits. ESI representatives are there to help you with any questions you may have about your medications and the plan options that may best suit your needs.

There will be two options for obtaining maintenance medications (up to a 90 day supply) through either Express Scripts Home Delivery Pharmacy or the Smart90 program. Please review the below Prescription Drug benefit summary offered by medical plan for additional details on this important benefit.

Here is a summary of your prescription drug benefits when you use an Express Scripts network pharmacy or the Smart90/mail order program.

	Choice Plus HSA Pre-65	Choice Plus Value HSA Pre-65	Current Cyro Pre-65 Plan
Retail *Up to 30-day supply (acute medications and first three fills of a maintenance medication)* *In-Network* Generic			
Generic	Plan pays 70%, after deductible	Plan pays 70%, after deductible	$7 copay
Non-preferred Brand	Plan pays 70%, after deductible	Plan pays 70%, after deductible	$20 copay
Preferred Brand	Plan pays 70%, after deductible	Plan pays 70%, after deductible	$50 copay
Out of Network	Plan pays 60%, after deductible	Plan pays 60%, after deductible	Plan pays 80% after deductible
Home Delivery Pharmacy or Smart90 (Benefit only available at a participating network pharmacy)			
Generic	$0, after deductible	$0, after deductible	$14 copay
Non-preferred Brand	$40, after deductible	$40, after deductible	$40 copay
Preferred Brand	$100, after deductible	$100, after deductible	$100 copay

Please note that the deductible for the Choice Plus HSA Plans and the Choice Plus Value HSA applies to both retail and mail order prescription drugs, EXCEPT for certain preventive prescription drugs. To find out if your prescription is covered as preventive and does not require a deductible or to learn about any cost-sharing required for preventive prescription medication, visit **www.expressscripts.com/evonik** and use the “Price a medication” tool.

Save Money if You Take a Maintenance Medication

With Express Scripts, you will have two cost-saving options for obtaining up to a 90-day supply of maintenance medications, such as for allergies, heart disease, high blood pressure or diabetes.

You can choose either Express Scripts Home Delivery Pharmacy or the Smart90 program. Both programs are detailed below. If you do not utilize one of these programs for your maintenance medications after the third fill you will pay 100% of the medication cost.

Express Scripts Home Delivery Pharmacy®

- When you use a particular Prescription Drug for an extended period of time (maintenance drug), you can use the Express Scripts Pharmacy® mail-order service. You are able to obtain up to a 90-day supply of Prescription Drugs through the mail order service. When you first begin taking a new medication that is being prescribed for regular long-term use, you may want to initially fill your prescription at a Participating Pharmacy rather than order a large supply through the Express Scripts Pharmacy® mail-order service. This safeguards you against wasting a 90-day supply that you may be unable to use if your Physician changes the medication or the dosage.

- If you take prescription medicine on an ongoing basis, you can order from Express Scripts Home Delivery Pharmacy. Once you start, you can refill and renew your prescriptions from the website or mobile app - and free standard shipping is included. With Express Scripts' mail-order pharmacy, you may obtain up to a 90-day supply of medication for each prescription.

Express Scripts Smart90 Program

- If you are prescribed a 90-day maintenance medication, and you initially fill your prescription at a Smart90 participating pharmacy, you will be subject to your elected Medical Plan option's Smart90 mail order prescription plan design. CVS and Walgreens are the primary Smart90 network retail pharmacies. If you fill your 90-day maintenance medication at a non-Smart90 participating pharmacy, you are allowed **three refills** of a maintenance medication (90-day supply) at any Express Scripts retail participating pharmacy. Each prescription will be subject to your elected Medical Plan option's retail prescription plan design.

- To continue to fill your maintenance medication at a retail pharmacy, beginning with the **fourth refill**, you must fill the prescription through a Smart90 CVS or Walgreens participating pharmacy or another Smart90 participating pharmacy if you live in an area where there is not a CVS or Walgreens. You pay your Medical Plan option's mail order copay, after any deductible, for each fill and in most cases you will save money.

Maintenance Medication Example

- You are prescribed a 90-day generic maintenance medication, and you are enrolled in the Choice Plus HSA Plan. The cost of a 30-day supply of the medication is $40. You fill the medication at an Express Scripts retail pharmacy (other than a Smart90 CVS or Walgreens retail pharmacy).

  - ***Your first three fills:*** Assuming you have already met the deductible, you would pay $12 for each fill (30% of $40), for a total of $36 for a 90-day supply.

  - ***After the third refill:*** If you choose the Express Scripts Home Delivery or Smart90 Program for your fourth fill for a 90-day supply, after you meet the annual deductible you would pay nothing because there's no copay for generic medications filled through Express Scripts Home Delivery or a Smart90 pharmacy after you meet the deductible.

If you continue to use the retail pharmacy (other than a Smart90 CVS or Walgreens retail pharmacy) for refills, you will be responsible for 100% of the medication's cost.

Drug Quantity Management

Drug quantity management, also known as DQM, is a program that's designed to make the use of prescription drugs safer and more affordable. It provides the medications you need for your health and the health of your family, while making sure you receive them in the quantity considered safe.

The DQM program follows guidelines developed by the U.S. Food & Drug Administration (FDA). These guidelines recommend the maximum quantities considered safe for prescribing certain drugs. Express Scripts uses FDA guidelines and other medical information to develop drug quantity management.

If the quantity on your prescription is too large, you can:

- Have your pharmacist fill your prescription as it's written, for the amount that your Medical Plan option covers;
- Ask your pharmacist to call your doctor. They can discuss changing your prescription to a higher strength, if one is available; or
- Ask your pharmacist to contact your doctor about getting a prior authorization. That is, your doctor can call Express Scripts to request that you receive the original amount and strength he/she prescribed. The Express Scripts representative will check your plan's guidelines to see if your medication can be covered for a larger quantity. Express Scripts' prior authorization phone lines are open 24 hours a day, seven days a week, so a determination can be made right away.

Prior Authorization

Prior authorization (PA) is a program that monitors certain prescription drugs and their costs to ensure your medication is appropriate, safe and cost-effective. Similar to health care plans that approve a medical procedure before it's done to ensure the necessity of the test, if you're prescribed a certain medication, that drug may need a prior authorization.

PA was developed under the guidance and direction of independent, licensed doctors, pharmacists and other medical experts. Together with Express Scripts, these experts review the most current research on thousands of drugs tested and approved by the U.S. Food & Drug Administration (FDA) as safe and effective. They recommend prescription drugs that are appropriate for a prior authorization.

If your prescription requires PA, ask your provider to call Express Scripts or to prescribe another medication that's covered under the Plan. Only your provider can give Express Scripts the information needed to see if your drug can be covered. Express Scripts' prior authorization phone lines are open 24 hours a day, seven days a week, so a determination can be made right away.

If you order your prescriptions through Express Scripts Home Delivery, Express Scripts pharmacy will contact your provider.

The Express Scripts formulary includes information about whether a medication requires PA. The formulary is available at **www.expressscripts.com**.

Step Therapy

Step therapy is a program for people who take prescription drugs regularly to treat a medical condition, such as arthritis, asthma or high blood pressure. In step therapy, drugs are grouped in categories, based on treatment and cost:

- **Front-line drugs** — the first step — are generic and sometimes lower-cost brand drugs proven to be safe, effective and affordable. In most cases, you should try these drugs first because they usually provide the same health benefit as a more expensive drug, at a lower cost.
- **Back-up drugs** — step 2 and step 3 drugs — are brand-name drugs that generally are necessary for only a small number of patients. Back-up drugs are the most expensive option.

Accredo Specialty Pharmacy

Specialty medications are drugs that are used to treat complex conditions, such as cancer, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they're administered by a health care professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

Under your prescription drug benefits program, some specialty medications may not be covered at your current pharmacy, or they may only be covered when ordered through Accredo, Express Script's specialty pharmacy. Accredo is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling. Services include:

- Access to 500 specialty-trained pharmacists on the phone;
- Access to 550 specialty-trained infusion nurses that meet patients face-to-face in their homes;
- Nutrition support for oncology patients;
- Therapy management programs to protect patient health and safety;
- Complete coordination of care between the medical benefit, pharmacy benefit and physicians; and
- Safe, prompt delivery of medications, including training on administration of the medication.

To find out whether any of your specialty medications need to be ordered through Accredo, please call Member Services at the toll-free number on your prescription drug ID card.

SaveonSP

SaveonSP cost-saving feature through Express Scripts will enable retirees with certain high-cost specialty drug needs to obtain financial assistance by leveraging manufacturers' copay assistance programs.

Enrolling in the SaveonSP program will reduce your out of pocket costs for your specialty medications. If you choose not to sign up with SaveonSP, you will pay a higher copay based on the specialty medication. The amount you pay will not count towards your deductible or out-of-pocket maximum.

Opioid Management Program

The opioid management program is aligned with the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention (CDC) to positively influence the prescribing and use of opioids to treat pain. The program limits days' supply, limits quantity of opioids and requires step therapy.

Important Additional Information About Heath Savings Account (HSA's)

Health Savings Accounts Offered under the Choice Plus HSA and Choice Plus Value HSA Plans

Health Savings Accounts (HSA) are tax-favored savings accounts available only to individuals enrolled in a high deductible health plan.

You can make contributions to your HSA up to the IRS limits and then use the money to pay for eligible health-related expenses. An HSA balance can accumulate quickly, within IRS guidelines, because HSAs have different funding options than other tax-advantage accounts. The HSA is a **bank account that you own**. Money that you contribute to the account can be rolled over from year to year, earn tax-free interest, and be invested.

Who is eligible to participate in a Health Savings Account?

The main requirement for opening an HSA is having a high-deductible health plan that meets IRS guidelines, including the annual deductible and out-of-pocket maximum. To be an eligible individual and qualify for an HSA, you must also meet the following requirements.

- You are not covered by any other non-HDHP health plan, such as a spouse's plan that covers you (including a health FSA), that provides any benefits covered by your HDHP plan.
- You or your spouse both are not covered by a general purpose health care flexible spending account (FSA) or health reimbursement account (HRA). This includes an FSA or HRA offered through your spouse's employer. Some HSA-compliant plan designs, such as a "limited-purpose" FSA or HRA, might be permitted.
- You are not enrolled in Medicare (Part A, Part B, Part C or Part D.).
- You do not receive health benefits under TRICARE.
- You cannot have received medical benefits from Veterans Administration (VA) for any non-service-connected disabilities at any time during the previous three months.*
- You cannot be claimed as a dependent on another person's tax return.

* Federal law defines "non-service-connected" disability as a disability that was not incurred or aggravated in line of duty in the active military, naval, or air service.

How much can be contributed to the Health Savings Account in 2022?

The IRS maximum contribution limit for calendar year 2022 is $3,650 for individual coverage or $7,300 for two-person or family coverage. Individuals from age 55 up to Medicare entitlement can contribute an additional “catch-up contribution.” The “catch-up” contribution limit for 2022 is $1,000. Even if your spouse is over age 65, you can still make HSA contributions up to these limits.

What happens if I contribute to my HSA over the IRS limits?

You must pay an excise tax on the excess HSA contribution and on any earnings of the excess HSA contribution. If in the next year you decreased your maximum contribution by the amount of your excess HSA contribution made the year before, you do not have to pay the excise tax again. If, however, you leave the excess HSA contribution in, and do not decrease your maximum HSA contribution by the amount of your excess HSA contribution made the year before, you will have to pay an excise tax each year the excess HSA contributions and earnings are in the HSA. Consult your personal tax advisor if you have questions about how to correct excess contributions to your HSA.

How do I set up an HSA account?

Evonik does not automatically set up an HSA on your behalf. It’s up to you to open one. You can open an HSA through your local bank, a credit union or with some financial planners. You may contribute your own money to your account by making a lump sum contribution or periodic payments at any time, in any amount up to a maximum limit established by the IRS. However, your trustee/custodian can impose minimum deposit and balance requirements. If you would like to make a change in your HSA, contact your financial institution who administers your account.

What expenses can be reimbursed with an HSA?

You can only use HSA dollars toward eligible health expenses – those you pay for out of your pocket for health care that’s provided to you, your spouse, and eligible tax dependents. Individuals under age 65 who use their accounts for non-medical expenses must pay income tax and a penalty on the amount withdrawn.

IRS rules govern expense eligibility, and generally, these rules state that medical care includes items and services that are meant to diagnose, cure, mitigate, treat, or prevent illness or disease. Below are some other examples:

- Your health plan deductible (the amount you pay before your plan starts paying a share of your costs).
- Your share of the cost for doctor’s office visits and prescription drugs.
- Your share of the cost for eligible dental care, including exams, X-rays, cleanings, and orthodontia.

- Your share of the cost for eligible vision care, including exams, eyeglasses, contact lenses, and laser eye surgery.
- Your tax qualified Long-Term Care premiums (the amount considered a qualified medical expense depends on your age).
- Your health insurance premiums if you are collecting federal or state unemployment benefits, or if you have COBRA continuation coverage through a former employer.
- You may not be reimbursed for any expense which is reimbursed by another source.

Can I make contributions to the HSA after age 65?

You cannot continue to make contributions to an HSA after you enroll in Medicare. Your HSA account balance will remain active, and you can continue to use your HSA dollars to pay for eligible medical expenses on a tax-free basis.

Additionally, if your spouse is under age 65, he or she can continue to contribute to his or her own HSA and may use that HSA to pay for your eligible expenses including Medicare premiums.

Once you enroll in Medicare, the annual contribution limit for that year will be prorated based on the number of months that you were eligible prior to enrolling in Medicare. Note that premium-free Part A coverage begins 6 months back from the date you apply for Medicare (or Social Security / Railroad Retirement Board benefits), but no earlier than the first month you were eligible for Medicare. So after you become eligible for Medicare, your annual contribution limit may be lower than the HSA contribution limits for other years. Consult your personal tax advisor to learn more about how your Medicare enrollment affects your family's HSA contributions.

Can I access my HSA funds after age 65?

You can continue to use your account tax-free for out-of-pocket qualified health expenses when you turn age 65.

For those over age 65, you can use your HSA to pay for the following expenses for you (and/or your spouse or eligible dependents) on a tax-free basis:

- Qualified health expenses
- Medicare Part B premiums
- Medicare Part D (prescription drug plan) premiums and copays
- Medicare Advantage HMO (Part C), (cannot be use for Medicare Supplement Plan or Medigap plan premiums)
- Retiree premiums for employer sponsored health insurance

- Pre 65 spouse's premiums if enrolled in a group plan

Once you turn age 65, you can also use your account to pay for things other than qualified medical expenses. If used for non-medical expenses, the amount withdrawn will be taxable as income but will not be subject to any other penalties.

Who decides whether the money I'm spending from my HSA is for a qualified health expense?

You are responsible for your HSA funds, meaning you are the decision maker. You decide how much to spend from the HSA for your medical services and prescription drugs – and when to spend it. You should familiarize yourself with what is considered qualified health expenses under federal tax law.

Qualified health expenses are determined by the IRS and include medical, prescription drug, dental, vision and certain premium expenses. Again, you are responsible for making sure your expenses are eligible according to IRS publication 502, available at www.irs.gov. Additionally, keep your receipts in case you need to defend your expenditures or decisions during an audit.

If you currently have an HSA through Optum Bank, you can continue to use it going forward. Current funds will remain in the account to be used for qualified health expenses.

How do I withdraw money from my HSA Bank Account?

Different HSA providers may have slightly different features. In general, you can withdraw funds via a debit card issued with the account. You can use the debit card to pay for things like prescription drugs at the pharmacy, or at a doctors' office that requires payment at the time of service or through ATM withdrawals or on-line transfers from your HSA to your savings or checking account. Consult your HSA provider for specific information about how to access to your HSA balance.

Do I need to keep my receipts showing what I withdrew from my account?

Yes, you should keep your receipts. If you exceed your deductible, you may need the receipts to send to your HDHP. If you are audited by the IRS, you may need to explain your HSA expenditures.

What are the survivor benefits associated with my HSA?

Based on current IRS regulations, if you name your spouse, the account remains an HSA, and your spouse will become the owner. When the beneficiary is not your spouse, the HSA ends on the date of your death. Your heir receives a distribution and the fair-market value becomes taxable income to the beneficiary—though the taxable amount can be reduced by any qualified medical expenses incurred by the decreased that are then paid by the beneficiary within a year of the death.

Failure to name a beneficiary at all means the assets in your account will be distributed to your estate and included on your final income tax return.

How do I report HSA activity on my tax return?

You are responsible to report the contributions and distributions to the IRS, and you are ultimately responsible for ensuring that your account transactions are within the allowed regulations. The IRS sets the applicable rules and reporting requirements for HSAs.

Please be advised that Evonik does not provide guidance on tax issues. Please consult with your tax advisor for information on your Health Savings Account.

Contact Information

Vendor	Telephone Number	Website
Mercer Retiree Service Center	1-855-684-6628.	www.EvonikRetireeBenefits.com
Mercer Billing and Payments	1-855-684-6628	You can log onto either www.EvonikRetireeBenefits.com or www.mercermyaccount.com
BCBS • Cyro Pre-65 Plan (Group #91606 Plan A, 91608 Plan B, C, D) • Choice Plus HSA (Group #91305) • Choice Plus Value HSA (Group #91306)	1-833-994-0014	www.AlabamaBlue.com To find a provider use prefix DHC or under the Select All Plans, choose BlueCard PPO
Express Scripts • Group #Evonik1	1-877-657-2496	www.expressscripts.com/evonik
Health Advocate	1-866-695-8622	

Disclaimer

In the event there is a conflict between the terms of the Plan documents and the descriptions in this Brochure or related materials, the Plan document will control and govern the operation of the Plans. Benefits are provided at Evonik Corporation's discretion and Evonik Corporation reserves the right to modify suspend, change or terminate the Plans and the benefits at any time.

Notices and Disclosures

Affordable Care Act Requirements

IRS Reporting

Form 1095 - Under the Affordable Care Act, Evonik is required to provide IRS Form 1095 by January 31, 2022 to all Pre-65 retirees and or dependents who were covered under an Evonik medical plan in 2021.

NOTICE OF PRIVACY PRACTICES

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

General Information About This Notice

Evonik Corporation and its affiliates (collectively, “Evonik”) continue their commitment to maintaining the confidentiality of your private medical information. This Notice describes Evonik’s efforts to safeguard your health information from improper or unnecessary use or disclosure. A federal law known as the “HIPAA privacy rules” requires the Evonik Health Plans to provide you with this summary of the Health Plans’ privacy practices and related legal duties and your rights in connection with the use and disclosure of your Health Plan information. Evonik and the Health Plans are required to abide by the terms of this Notice as currently in effect.

The Health Plans

This Notice describes the privacy practices of the following health benefits programs offered by Evonik Corporation and its participating affiliates (collectively referred to as the “Health Plans”):

- Retiree medical plan under the Evonik Corporation Consolidated Retiree Welfare Benefits Program

These Health Plans provide health benefits to eligible Evonik retirees and their eligible dependents.

What Information is Protected?

The HIPAA privacy rules require the Health Plans to establish policies and procedures for safeguarding a category of medical information called “protected health information,” or “PHI,” received or created in the course of administering the Health Plans. PHI is health information that can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or payment for your health care. A claim form for medical benefits and the explanation of benefits

statements (EOBs) sent in connection with payment of your claims are examples of documents containing PHI.

This Notice only applies to health-related information received by or on behalf of the Evonik Health Plans.

Uses and Disclosures That Do Not Require Your Authorization

The Health Plans may use or disclose your PHI in certain permissible ways described below. To the extent required under the HIPAA privacy rules, the PHI used and disclosed by the Health Plans will be limited to the minimum amount of PHI necessary for these purposes.

Payment. The Health Plans may use and disclose your PHI to obtain payment for your coverage and to determine and fulfill the Health Plans' responsibility to provide health benefits – for example, to make coverage determinations, administer claims, and coordinate benefits with other coverage you may have. The Health Plans also may disclose your PHI to another health plan or to a health care provider for its payment activities – for example, for the other health plan to determine your eligibility or coverage, or for the health care provider to obtain payment for health care services provided to you.

Health Care Operations. The Health Plans may use and disclose your PHI for their health care operations – for example, to arrange for medical review, for disease management, to conduct quality assessment and improvement activities, or for underwriting. However, the Health Plans are prohibited from using or disclosing your genetic information for underwriting purposes. The Health Plans also may disclose your PHI to another health plan or a health care provider that has or had a relationship with you for it to conduct quality assessment and improvement activities; for accreditation, certification, licensing, or credentialing activities; or for the purpose of health care fraud and abuse detection or compliance – for example, for the other health plan to perform case management or health care provider performance evaluations, or for the health care provider to evaluate the outcomes of treatments or conduct training programs to improve health care skills.

Treatment. The Health Plans may disclose your PHI to your health care provider for its provision, coordination, or management of your health care and related services – for example, for managing your health care with the Health Plans or for referring you to another provider for care.

To Comply with Law. The Health Plans may use and disclose your PHI to the extent required to comply with applicable law.

Disclosures to Evonik Health Plan. The Health Plans may disclose your PHI to certain employees or other individuals under Evonik's control to allow Evonik to administer the Health Plans, as described in this Notice. In addition, Evonik may use or disclose "summary health information" for purposes of obtaining premium bids or modifying, amending, or terminating the Health Plans. Summary health information is information that summarizes claims history, claims expenses, or types of claims

experienced by individuals for whom Evonik provides benefits under the Health Plans and from which the individual identifying information, except for five-digit zip codes, has been deleted. Evonik cannot use your PHI obtained from the Health Plans for any employment-related actions without your written authorization.

Evonik uses and discloses Health Plan enrollment/disenrollment information for payroll-related activities. However, this enrollment/disenrollment information is held by Evonik in its role as the employer and is not subject to the HIPAA privacy rules or this Notice.

- **Third Party Providers (Business Associates).** The Health Plans contract with third party administrators and various service providers, called “business associates,” to perform certain plan administration functions. The Health Plans’ business associates will receive, create, use, and disclose your PHI, but only after the business associates have agreed in writing to appropriately safeguard and keep confidential your PHI. Blue Cross Blue Shield of Alabama, is an example of Health Plan business associates. Business associates may also use or disclose your PHI on behalf of the Health Plans, as described in this Notice.

- **Disclosures to Family Members and Friends**. The Health Plans may disclose your PHI to your family members, close friends, or other persons involved in your health care if you are present and you do not object to the disclosure (or if it can be inferred that you do not object), or, if you are not present or are unable to object due to incapacity or emergency, the disclosure is in your best interest. Following your death, the Health Plans may disclose your PHI to your family members, close friends, or other persons who were involved in your health care unless doing so would be against your stated preferences. Disclosure will be limited to your PHI that is directly relevant to the person’s involvement in your health care.

- **Marketing Communications**. The Health Plans may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be useful to you. The Health Plans may also use and disclose your PHI to communicate face-to-face with you to encourage you to purchase or use a product or service that is not part of the health benefits provided by the Health Plans, or to provide a promotional gift of nominal value to you.

- **Disclosures in Connection with Regulatory Inquiry**. The Health Plans may disclose your PHI to the U.S. Department of Health and Human Services in connection with an inquiry or review of the Health Plans’ compliance with the HIPAA privacy rules.

- **Judicial and Administrative Proceedings.** The Health Plans may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

- **Workers’ Compensation**. The Health Plans may disclose your PHI as necessary to comply with workers’ compensation or similar laws or programs. Research. The Health Plans may use or disclose your PHI for research purposes, as long as certain privacy-related standards are satisfied.

- **Public Health.** The Health Plans may use or disclose your PHI for certain public health activities, including to a public health authority for the prevention or control of disease, injury, or disability; to a proper government or health authority to report child abuse or neglect; to report reactions to medications or problems with products regulated by the Food and Drug Administration; to notify individuals of recalls of medication or products they may be using; to notify a person who may have

been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition; or to provide immunization information to a school about a student or potential student.

- **Other Uses and Disclosures.** In addition, the Health Plans may use or disclose your PHI in limited circumstances as permitted or required by law, including:
    - For certain health oversight activities, such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to health care provision or public benefits or services.
    - To police or other law enforcement officials as required by law or in compliance with a court order or other process authorized by law.
    - To an appropriate government authority to report suspected instances of abuse, neglect, or domestic violence.
    - To prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.
    - If you are deceased, to allow a coroner or medical examiner to identify you or determine your cause of death, for tissue donation purposes, or to allow a funeral director to carry out his or her duties.
    - For purposes of public safety or national security.
    - To specialized government units, such as the U.S. military or U.S. Department of State, for certain government purposes.

State law may further limit the permissible ways the Health Plans use or disclose your PHI. If an applicable state law imposes stricter restrictions, the Health Plans will comply with that state law.

Uses and Disclosures with Your Written Authorization

A Health Plan may use or disclose your PHI for a purpose other than as described above only if you give the Health Plan your written authorization. Most uses and disclosures of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures that constitute a sale of your PHI require your authorization under the HIPAA privacy rules. If you provide a Health Plan with your authorization to use or disclose your PHI, you may revoke your authorization at any time by delivering a written revocation statement to the Privacy Officer. If you revoke your authorization, the Health Plans will no longer use or disclose your PHI except as described above (or as permitted by any other authorizations that have not been revoked). However, the Health Plans cannot retrieve any PHI disclosed to a third party in reliance on your prior authorization.

Your Individual Rights

The HIPAA privacy rules provide you with certain rights regarding your PHI.

- **Right to Request Additional Restrictions**. You may request restrictions on a Health Plan's use and disclosure of your PHI. While the Health Plans will consider all requests for additional restrictions carefully, the Health Plans are not required to agree to a requested restriction. If you wish to request restrictions on a Health Plan's use and disclosure of your PHI, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is used or disclosed by third party vendors (business associates) that administer the Health Plans (for example, most medical PHI is maintained by the medical claims administrators). To request restrictions on the use or disclosure of your PHI by these vendors, you may wish to contact the vendors directly. For more information on your right to request restrictions, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).

- **Right to Receive Confidential Communications.** You may request to receive your PHI by alternative means of communication or at alternative locations. Your request must specify how or where you wish to be contacted. The Health Plans will try to accommodate any reasonable request for confidential communication. Please note that in certain situations, such as with respect to eligibility and enrollment information, the Health Plans are obliged to communicate directly with the employee/retiree rather than a dependent unless your request clearly states that disclosure of that information through the normal methods could endanger you. If you wish to request confidential communication of your PHI, you may obtain a request form from the Privacy Officer. Most communications of PHI relating to your health benefits are made by third party vendors (business associates) that administer the Health Plans. To request confidential communication of your PHI by these vendors, you may wish to contact the vendors directly. For more information on your right to request confidential communication of your PHI, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).

- **Right to Inspect and Copy Your PHI.** You may request access to certain Health Plan records that contain your PHI in order to inspect and request copies of those records. If you request copies, the Health Plans may charge you copying, mailing, and labor costs. To the extent that your PHI is maintained electronically, you may request that the Health Plans provide a copy to you or to a person or entity designated by you in an electronic format. Under limited circumstances, a Health Plan may deny you access to a portion of your records. If you desire access to your records, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is created or maintained by third party vendors (business associates) that administer the Health Plans. For access to that information, you may wish to contact the vendors directly. For more information on your right to inspect and request copies of your PHI, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).

- **Right to Amend Your Records.** You have the right to request that the Health Plans amend your PHI maintained in the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Health Plans and any other records used by or for the Health Plans to make decisions about your benefits. The Health Plans will comply with your request for amendment unless special circumstances apply. A Health Plan may deny your request for amendment if you do not provide a reason to support your request or if the Health Plan believes that the information is accurate. In addition, a Health Plan may deny your request if you ask it to amend information that was created by another health plan or health care provider (but the Health Plan will inform you of the source of the information, if known). If your physician or other health care provider created the information that you desire to amend, you should contact the health care provider to amend the information. To make a request for amendment, you may obtain a request form from the

Privacy Officer. Most PHI relating to your health benefits is created or maintained by third party vendors (business associates) that administer the Health Plans. To request amendment of that information, you may wish to contact the vendors directly. For more information on your right to request amendment of your PHI, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).

- **Right to Receive an Accounting of Disclosures.** Upon request, you may obtain an accounting of certain disclosures of your PHI made by the Health Plans made within six years of the date of your request. The accounting will generally be provided free of charge, but if you request an accounting more than once during a twelve (12) month period, the Health Plans may charge you a reasonable fee for any subsequent accounting statements. You will be notified of the costs involved, and you may choose to withdraw or modify your request before you incur any expenses. The accounting will not include all disclosures of your PHI. For example, the accounting will not include disclosures (i) to carry out treatment, payment or health care operations activities; (ii) made to you; (iii) made to friends or family members involved in your care; (iv) made pursuant to your written authorization; (v) for national security or intelligence purposes; or (vi) to correctional institutions or law enforcement officials. If you wish to request an accounting, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is used or disclosed by third party vendors (business associates) that administer the Health Plans. For an accounting of disclosures by a Health Plan vendor, you may wish to contact the vendor directly. For more information on your right to request an accounting, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).

- **Right to Receive Paper Copy of this Notice.** You may obtain a paper copy of this Notice upon request to the Privacy Officer.

- **Right to Notification of a Breach of Your PHI.** You will be notified in the event of an improper use or disclosure of your PHI if a Health Plan determines that the privacy of your PHI was likely compromised.

- **Personal Representatives.** You may exercise your rights through your personal representative who has authority under applicable state law to make health-related decisions on your behalf. Your personal representative will be required by the Health Plans to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or evidence that you are the parent of a minor child. The Health Plans reserve the right to withhold your PHI from your personal representative in certain limited circumstances.

- **For Further Information; Complaints.** If you would like additional information about your privacy rights, contact the Privacy Officer listed at the end of this Notice. If you are concerned that a Health Plan has violated your privacy rights, or if you disagree with a decision that a Health Plan made about access to your PHI or any of your other rights described above, you should contact the Privacy Officer. Evonik and the Health Plans take your complaints very seriously. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the correct address for the Secretary. Neither Evonik nor the Health Plans will retaliate against you if you file a complaint with the Privacy Officer or the Secretary.

Effective Date and Application of this Notice Effective Date. This Notice is effective as of July 20, 2018.

Right to Change the Terms of this Notice. This Notice is subject to change. If the Health Plans revise this Notice, they may make the new Notice terms effective for all of your PHI that they maintain, including any information created or received prior to issuing the updated Notice. If the Health Plans make a material change to this Notice, you will be notified of the change if you are then covered by a Health Plan. In addition, any new Notice will be posted at your site of employment and on the Evonik HR Direct USA intranet website. You may also obtain the most current copy of the Notice by contacting the Privacy Officer (contact information below).

Privacy Officer

You may contact the Privacy Officer at:

Law Department Evonik Corporation
299 Jefferson Road
Parsippany, NJ 07054

ATTENTION: HIPAA Privacy Officer

Telephone Number: (800) 334-8772 Email: compliance.program@evonik.com

Keep Your Health Plans Informed of Address Changes

In order to protect your and your family's Health Plan privacy rights, you should keep Evonik's Human Resources Department informed of any changes in your address and the addresses of your covered family members. In the event that your PHI has been breached, the Health Plans will notify you at your address on record.

Women's Health and Cancer Rights Act Of 1998

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires coverage for the following services under the Medical Benefit Options in the Evonik Benefits Plan.

In the case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and,
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan. The annual deductibles and coinsurance are listed in your benefit plan documents. If you would like more information on WHCRA benefits, contact the Mercer Retiree Service Center at 1-855-684-6628.

The Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).