SUMMARY PLAN DESCRIPTION

EVONIK CORPORATION CONSOLIDATED RETIREE WELFARE BENEFITS PROGRAM

For Retirees

Effective January 1, 2021

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EVONIK RETIREES
(AND THEIR ELIGIBLE DEPENDENTS)
IN THE EVONIK CORPORATION CONSOLIDATED
RETIREE WELFARE BENEFITS PROGRAM

Effective January 1, 2021

This document is the Summary Plan Description (SPD) for the Evonik Corporation Consolidated Retiree Welfare Benefits Program (the "Plan") for specific Retirees of Evonik Corporation and other participating Employers. This SPD outlines the rights and benefits of covered Retirees and their Dependents and describes the major provisions of the Plan, as in effect on January 1, 2021.

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. Like a glossary.

The complete terms and conditions of the Plan are described in a complex legal document. Plan benefits are paid only if provided for in the official Plan document or the Program booklets. Program booklets are specific to each benefit.

There are Program booklets for the following self-funded benefits: medical, vision, pharmacy, and most dental benefits. If there are any differences between this SPD and the official Plan document, and the Program booklets, the Program booklets will govern. The Program booklets, together with this Base SPD, will constitute your SPD for each ERISA plan.

Some benefits are fully-insured coverages, like some dental benefits, life insurance benefits, some Medicare Advantage plans, and any HMO plan. If you elect coverage under a fully insured option, the certificate of coverage and/or summary of benefits booklet is considered a part of this SPD. In this case, you will receive a certificate detailing your benefit coverage. In the event of a conflict between the certificate of coverage or summary of benefits booklet and the terms described in this SPD, the certificate of coverage or summary of benefits booklet will govern, except as specifically noted in this document. So please review that certificate of coverage or summary of benefits booklet because it contains details of your coverage levels and costs.

The terms "you" and "your" as used in this Summary Plan Description refer to a Retiree, who meets all the eligibility and participation requirements under the Plan, called a Covered Person. A Covered Person also can include an eligible Retiree's covered Dependents. Receipt of this SPD does not guarantee that the recipient is a Retiree under the Plan and/or otherwise eligible for benefits under the Plan.

An individual who was a union employee prior to retirement or termination of employment is not a Retiree unless the individual is eligible for retiree health or life

insurance benefits under the terms of the bargaining agreement in effect at the time of his or her retirement or termination of employment.

INTRODUCTION

Participation in the Plan will take effect once you enroll in accordance with the Company's procedures. Enrollment is not automatic in all programs. If you do not enroll in applicable programs when initially eligible, you may lose coverage under the Plan forever. Important timeframes apply to elections and coverage.

The Plan provides benefits only for events and expenses incurred by Retirees and their eligible Dependents 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, or on the date of death in the case of life insurance. If the Plan is terminated, the rights of Retiree and eligible Dependents 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 a treatment or service is medically necessary according to generally accepted medical standards of care.

Important Information About the Plan

The Plan is a retiree life and health Plan and is a "welfare benefit Plan" under Section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA). Some health plan benefits are self-funded, and some are fully insured. The self-funded medical options are funded by the general funds of the Company and the required contributions made by Covered Persons. Fully insured benefits are paid by the policy insurer. Each of these options is further detailed in the Program booklets.

The Plan generally is administered by third party Claims Administrators on behalf of the Plan Administrator. However, for the fully-insured programs, the Claims Administrator is the insurer.

GENERAL INFORMATION

Plan Name:	Evonik Corporation Consolidated Retiree Welfare Benefits Program
Plan Number:	502
Employer Tax Identification Number:	63-0673043
SPD Effective Date:	January 1, 2021
Plan Year:	January 1 to December 31 (the Plan's fiscal records are kept on a Plan Year basis)
Annual Enrollment	The annual enrollment period generally occurs in October (schedule determined each year). A Retiree may make elections during this period for the following Plan Year. A Retiree may elect to change coverage options only as allowed under the terms of the Plan.
Plan Sponsor/Company:	Evonik Corporation Attn: Director, Benefits Americas 299 Jefferson Road Parsippany, NJ 07054-0677
Plan Administrator and Named Fiduciary	Evonik Corporation Administrative Committee c/o Evonik Corporation 299 Jefferson Road Parsippany, NJ 07054-0677 Telephone: (800) 334-8772 Fax: (973) 929-8111
Agent for Service of Legal Process:	Legal Department - Evonik Corporation c/o – Evonik Corporation 299 Jefferson Road Parsippany, NJ 07054-0677 Telephone: (800) 334-8772 Fax: (973) 929-8111 *Service may also be made upon the Plan Administrator*
Union Employees	The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any the relevant collective bargaining agreement(s) may be obtained by participants upon written request to the Plan Administrator and is available for examination.
Participating Employers	A list of Participating Employers is available upon request from Mercer.

PROGRAM ELIGIBILITY

Each Program (medical, dental, vision, and life) has its own eligibility rules. The rules below generally reflect the Evonik self-funded arrangements. If you are covered under an insured plan (such as dental coverage, life insurance or an HMO), check the insurance certificate for eligibility.

Retiree Health Eligibility

In general, you are eligible for benefits under this Plan as a Retiree if you are a former Employee of the Employer who meets *all three* of the below:

- You were treated and/or classified by an Employer as an Employee immediately prior to your retirement or termination of employment;
- You were eligible for benefits under the Evonik Corporation Consolidated Welfare Benefits Program immediately prior to your retirement or termination date; and
- You retire from employment with an Employer at or after age 55 with 5 Years of Service, *except* for the following Employee groups.
    - for a former Employee who was initially hired by Huls America Inc./ CREANOVA, either you (i) were employed on December 31, 1999 with 5 Years of Service, or (ii) you were employed on December 31, 1999, and as of such date were age 50 – 54, and your age plus Years of Service equaled 70.
    - for a former Employee who was initially hired by Evonik Cyro, you retire from employment after age 55 with 10 Years of Service, but Fortier union and non-union employees are not eligible Retirees of Evonik Cyro.
        - If you retire before February 1, 1994, or if you reached age 55 before December 31, 1994, you may qualify for Cyro retiree medical plans A or B.
        - If you retire on or after February 1, 1994 at or after age 55 with 10 or more Years of Service, you may qualify for Cyro retiree medical plan C if you either: (i) were hired before July 1, 2002, or (ii) were hired prior to June 1, 2005 at the Wallingford location as a union employee, or (iii) were hired on June 1, 2005 as a non-union employee at the Wallingford location as part of the Cytec acquisition.
        - If you retire on or after July 1, 2002 at or after age 55 with 10 or more Years of Service you may qualify for Cyro retiree medical plan D.
    - for a former Employee of Evonik Oil Additives initially hired before January 1, 2017, you retire: (i) after age 60 with 15 Years of Service or (ii) after age 56 with 30 Years of Service.
    - for a former Employee of Evonik Oil Additives hired in 2017 or later, you must retire from employment with an Employer at or after age 55 with at least 5 Years of Service.

Special Retiree Medical Eligibility Rules for Cyro

If you are a Retiree of Evonik Cyro, you are not eligible for retiree medical coverage while you have medical coverage available to you under another employer's group plan. Therefore, if you work for a new employer after you leave your Evonik Employer, and if you have other group medical coverage available to you through that new employer, then you are ineligible for Retiree medical coverage under this Plan. You are ineligible for Retiree medical coverage during any period that you are eligible for other employer medical coverage, even if you do not elect to enroll in that other coverage. If the medical coverage available to you from your new employer ceases, you may elect Retiree medical coverage at that time by contacting the Mercer Retiree Service Center at +1 855-684-6628.

Retiree Life Insurance Eligibility

Only certain groups are eligible for Retiree life insurance. Groups that are eligible for Retiree life insurance generally include:

- A Retiree initially hired by Oil Additives prior to January 1, 2017, and who meets the age and service requirements in the *Retiree Health Eligibility* section;
- A Retiree initially hired by Stockhausen LA prior to April 26, 2006, and who meets the age and service requirements in the *Retiree Health Eligibility* section:
- A Retiree initially hired by Cyro prior to July 1, 2002, and who meets the age and service requirements for Cyro plans A, B or C in the *Retiree Health Eligibility* section;

A USW or SEIU Retiree at the Evonik Mapleton facility who meets the age and service requirements in the in the *Retiree Health Eligibility* section; and SEIU Mapleton union employees who retire on or after 12/1/20 are not eligible for retiree life insurance. Any SEIU Mapleton union employee who retired prior to 12/1/20 receives the life insurance.

- A union retiree at the Evonik Piscataway facility hired before April 1, 2015, and who meets the age and service requirements in the in the *Retiree Health Eligibility* section; and
- A CREANOVA employee on December 31, 1999 who was at least age 62 with 5 or more Years of Service.

If you are in one of the above groups, you can find out more about your eligibility and retiree life coverage by calling Mercer at the Mercer Retiree Service Center at +1 855-684-6628. If you are eligible, Hartford will send you a certificate of coverage for your Retiree life insurance detailing the level of your retiree life insurance benefits.

Eligible Dependents

If you are a Retiree eligible for Retiree health coverage, you may also elect Retiree health coverage for your Dependents when you enroll. When you enroll your eligible Dependents for coverage, you will be required to certify that each person meets the definition of an eligible Spouse (as described in the *Defined Terms* section) and/or Dependent child as described below. Enrolling individuals who do not qualify for Dependent coverage under the Plan is considered fraudulent and may result in retroactive cancellation of coverage. If you are unsure about whether a family member meets the definition of an eligible Dependent under the Plan, contact the Mercer Retiree Service Center at +1 855-684-6628.

A Retiree's Dependents include his or her Spouse at the time of retirement, and eligible children from birth until 26 years of age, regardless of student or marital status, financial dependence, or place of residence. An eligible child means the Retiree's biological children, stepchildren, adopted children, foster children, and children who are the subject of a QMCSO if they meet the definition of Dependent under the Plan. Dependents also include children who live with the Retiree and for whom the Retiree is Legal Guardian and recognized by a court of law as having the duty of taking care of and manage the property and rights of a minor child.

A Retiree's eligible child can be a Dependent under the Plan until the child reaches age 26. However, if a Retiree's covered child is incapable of self-sustaining employment by reason of mental or physical handicap, is primarily dependent upon the covered Retiree for support and maintenance, and is unmarried upon reaching age 26, coverage may be continued beyond age 26 for as long as the Retiree's child remains disabled. The Retiree will be required to submit satisfactory proof within thirty-one (31) days after the Dependent child's 26th birthday that the Dependent remains unable to work and is principally dependent upon the Retiree. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent child's 26th birthday, subsequent proof of the child's disability and dependency. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have any such disabled Dependent child examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to confirm the child's incapacity.

No person may be covered both as a Retiree and Dependent, and no person may be covered as a Dependent of more than one Retiree. If both husband and wife are Retirees (or if one is a Retiree and the other is an active Employee participating in the Evonik Medical Plan), their children may be covered as Dependents of either the husband or wife, but not of both.

ENROLLMENT

You are eligible to enroll in this Plan as a Retiree, beginning on the first day of the month after you terminate employment or retire, but only if you satisfy *all three* of the following:

- You meet all of the eligibility requirements as described under the *Program Eligibility* section above;
- You timely enroll in the Plan as described below; and
- You make any required contributions towards the cost of Plan coverage.

You must enroll within 31 days of your retirement or termination of employment from an Employer. However, if you are Cyro Retiree, then special enrollment rules apply to you, as described above in the section *Special Retiree Medical Eligibility Rules for Cyro*. In all cases, you will receive a retirement enrollment package from the Mercer Retiree Service Center.

How to Enroll

You can enroll in Retiree health coverage in any one of the three ways listed below.

- You complete the retiree enrollment form and return it to Mercer in the envelope.
- You enroll online by accessing our new Evonik Retiree website at www.evonikretireebenefits.com. You will need your Mercer Certificate Number (beginning with 26019) located on your 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.
- You enroll by phone by calling the Mercer Retiree Service Center at 1 855-684-6628. Mercer representatives can take your enrollment information over the telephone.

If you do not timely enroll during your applicable enrollment period, you will no longer be eligible for Retiree health benefits for you and your Dependents. You and your eligible Dependents will be deemed to waive Retiree health coverage, and you and your Dependents may not elect to enroll in Retiree health coverage at any other later time.

Annual Enrollment

If you are eligible each fall at annual enrollment, you will receive information from the Mercer Retiree Center about the Retiree options available to you, including any applicable cost. You can make changes to your Retiree health coverage during the annual enrollment period. Any changes made during annual enrollment will be effective

as of January 1st of the next year. Changes to your Retiree health coverages must be made during the specified annual enrollment period.

RETIREE HEALTH COVERAGE OPTIONS

The Plan helps Retirees and their covered Dependents pay for health care. Most Retirees and their Dependents can choose to enroll in the following Retiree health options, based on whether the Covered Person is eligible for Medicare (post-65) or whether the Covered Person is not eligible for Medicare (pre-65). Different Retirees can enroll in different health coverage options, depending on the Retiree's initial Employer, hire date, age, and Years of Service. See the below chart for more information on Retiree health coverage options. But for more information on your eligibility and coverage options, please contact the Mercer Retiree Service Center at 1 855-684-6628.

Retiree Health Pre-65 and Post-65 Coverage Options

Health Plan Options	Evonik*	Some Stock-hausen LA*	Some Oil Additives*	Cyro Plan A*	Cyro Plan B*	Cyro Plan C and D*	Lockland Union*	Piscat-away Union*
BCBS Premium	Pre-65	Pre-65	Pre-65					
BCBS Core	Pre-65	Pre-65	Pre-65					
BCBS Choice HSA	Pre-65	Pre-65	Pre-65	Pre-65	Pre-65	Pre-65		
BCBS Value HSA	Pre-65	Pre-65	Pre-65	Pre-65	Pre-65	Pre-65		
BCBS Tradi-tional Indemnity	Post-65	Post-65						
BCBS Cyro Plan A				Pre-65 and Post-65				
BCBS Cyro Plan B					Pre-65 and Post-65			
BCBS Cyro Plan C/D						Pre-65 and Post-65		
Aetna Medicare Advantage			Post -65					
Horizon Medicare Advantage								Post-65
BCBS Union PPO							Pre-65 and Post-65	Pre-65 and Post-65
BCBS Dental		Pre-65 and Post-65						
Aetna Dental		Pre-65 and Post-65	Pre-65					
Delta Dental			Pre-65					
VSP Vision			Pre-65					

**For the above chart, Evonik Retirees includes all Retirees who meet eligibility, age and service requirements described in the Retiree Health Eligibility section, except for the following eligible Retirees who meet their specific age and service requirements but have different health plan options: (i) Retirees initial hired by Stockhausen LA prior to April 26, 2006, (ii) Retirees initially hired by Oil Additives before January 1, 2017, (iii) Retirees initially hired by Cyro, and (iv) Retirees formerly covered by a collective bargaining agreement at the Lockland or Piscataway facilities.*

Medicare Eligible Retiree with Non-Medicare Dependents

The below rules apply to all Retirees, regardless of the Retiree health coverage options available to you. If you are eligible for Medicare, but one or more of your covered Dependents are non-Medicare eligible, you can choose one of four following options.

- You can terminate your Retiree medical coverage for yourself and all Dependents. In this case, neither you nor your Dependents can enroll in Retiree medical coverage at a later time.
- You can terminate Retiree medical coverage *only* for your covered Dependents. In this case you can enroll in the post-65 Retiree Plan coverage available to you, but your Dependents cannot enroll in Retiree medical coverage at a later time.
- You can terminate *only* your Retiree medical coverage, and your non-Medicare eligible Dependents can enroll in one of the available non-Medicare medical options. Coverage for your non-Medicare Dependents will terminate after your covered Dependent becomes Medicare eligible, or no longer meets the definition of a Dependent, whichever comes first.
- You can continue Retiree medical coverage for both you and your Dependents. If you continue your Plan coverage, you must switch your coverage to the post-65 Retiree coverage available to you. Your non-Medicare eligible Dependents may enroll in one of the available non-Medicare coverage options. After your Dependent becomes Medicare eligible, you may enroll both you and your Dependents in the post-65 Retiree coverage available to you.

In all cases, you can contact Mercer for more information on the Retiree health options in which you and your Dependents may enroll.

Non-Medicare Retiree with Medicare-Eligible Dependents

If you are a Retiree who is not Medicare-eligible, but one or more of your Dependents is eligible for Medicare, then you can choose one of the following options for Retiree medical coverage.

- You can terminate your Retiree medical coverage for yourself and all Dependents. In this case, neither you nor your Dependents can enroll in Retiree medical coverage at a later time.
- You can terminate your Retiree medical coverage for your Dependents. If you terminate your covered Dependents' coverage, you can remain in a non-Medicare medical coverage option available to you. After you become eligible for Medicare, you can enroll in post-65 Retiree coverage available to you.
- You can continue coverage for you and your Medicare-eligible Dependents. If you continue coverage for your Medicare-eligible Dependents, your Medicare-eligible Dependent must be enrolled in the available post-65 Retiree coverage option, and you may enroll in one of the non-Medicare coverage options available to you. In order to continue coverage for your Medicare eligible Dependent, you must remain a Covered Person under the Plan.

In all cases, you can contact Mercer for more information on the Retiree medical options in which you and your Dependents may enroll.

Pharmacy Benefits

All Retirees receive prescription drug coverage through Express Scripts, and not through your retiree medical option. Be sure to use your retiree ID card sent by Express Scripts to fill your prescriptions after you and your Dependents enroll in Retiree medical coverage.

COST OF COVERAGE

The amount you pay towards the cost of your Retiree coverages can be based on a number of factors, including some or all of the following:

- Your elected coverage (individual coverage or family coverage);
- Your years of service with the Employers;
- Your age;
- Your initial Employer;
- Your initial date of hire; and
- The annual cost sharing determined each year by the Company.

In all cases, you can contact Mercer for more information on the cost of Retiree medical coverage for you and your Dependents.

HEALTH SAVINGS ACCOUNT

If you elect coverage under the BCBS of AL Choice Plus HSA or Blue Cross Blue Shield Choice Plus Value HSA coverage options, then you can contribute to a Health Savings Account ("HSA"). You are not required to contribute to a HSA, and only eligible individuals may fund their HSA. Generally, under federal tax law, you are eligible to contribute to a HSA if you *are* covered by a high deductible health plan, and if you *are not*: (i) covered by another non-high deductible plan health, (i) enrolled in Medicare, and (iii) claimed as a dependent on someone else's tax return. 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.

Your HSA can be used to pay your deductible or any eligible unreimbursed expenses under your Retiree health coverages. If you do not use all of your HSA funds during the year, your HSA balance is carried over to the following year and receives allocated earnings and losses based on the investments you choose. Evonik does not contribute to HSAs for a Retiree or their Spouse or Dependents.

ELECTION CHANGES DURING THE YEAR

In general, you cannot change your Retiree health coverage during the year unless you experience a Qualified Change in Coverage (as explained below) or become eligible for Medicare. You may, however, terminate health coverage for you, your Spouse, and/or your Dependents at any time during the year.

Qualified Change in Coverage

The following events are considered a Qualified Change in Coverage that allows you to change your Retiree health coverage during a year.

- Changes in your legal marital status - such as divorce, legal separation, death of your Spouse, or annulment - but a new Spouse after your initial enrollment cannot be added to your Retiree coverage.
- Changes in the number of your Dependents, such as the birth or death of a Dependent child.
- Changes in your Dependent's eligibility, such as when your Dependent child reaches age 26.
- Changes in the residence for you, your Spouse or Dependents, if it causes you or your Spouse or Dependents to lose eligibility under the Plan or a Plan coverage option.
- Changes in the employment status for you or your Spouse or Dependents, if it affects eligibility for the Plan or a coverage option, such as termination or commencement of employment, a reduction or increase in hours of employment, or a commencement or return from an unpaid leave of absence.
- Loss of other coverage for your Spouse or Dependents, if your Spouse or Dependent has other health insurance coverage and loses that coverage in the middle of the year.
- A Qualified Medical Child Support Order or QMCSO is received. Then subject to procedures established by the Plan Administrator, a Retiree's election may be changed in order to add or discontinue coverage to a Dependent child in accordance with the terms of a QMCSO.
- Change in the eligibility for Medicaid or CHIP for you, your Spouse or Dependent. In this case, you will have a special enrollment period of 60 days from the date of this Qualified Change in Coverage event to make your Plan election.

- Change in eligibility for Medicare for you or your Spouse or Dependent.
- Other change events that the Plan Administrator determines will permit revocation of an election (and, if applicable, the filing of a new election) during a year under federal tax law.

Rules for Mid-Year Election Changes

Any election change in your Retiree health coverage must be consistent with your Qualified Change in Coverage event. Your election change also is subject to other requirements established by the Plan Administrator. For example, if you have a Dependent child, you will be permitted to add coverage for your new Dependent child, but you will not be permitted to change your medical coverage option.

Generally, if a Qualified Change in Coverage event happens, then you may make an appropriate election change within 31 days of the event. For example, if you have a new Dependent child, you can change from single Retiree health coverage to two-person Retiree health coverage. However, if your Qualifying Change in Coverage is due to a loss of eligibility or to new qualification for Medicaid or CHIP subsidy, you will have 60 days to make an election change. Your new coverage elections will take effect on the day of the Qualifying Change in Coverage event, but *only if* you timely enroll. Any resulting changes to your required contribution will begin as of the first day of the following month. If you do not make the change within the 31-day or 60-day election period, you must wait until the next annual enrollment to make any changes, or until you have another Qualifying Change in Coverage event, whichever comes first. To find out if you have a Qualified Change in Coverage event, and which types of changes, if any, are permitted, you should contact Mercer.

CLAIM PROCEDURES

Each benefits booklet or certificate of coverage explains how to file and appeal a claim for the specific benefit option. However, with all benefit options, if you have exhausted your appeal rights under the claims procedures, you have time limits to file suit in federal court. See the SPD, benefits booklet, or certificate of coverage for the appropriate deadlines. If you have any questions with regard to filing a claim, you may contact Mercer.

General Rules for Filing a Claim

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 (as defined in the medical booklet by the Claims Administrator), 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 medical 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 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.

Claim Rules for Self-Insured Coverage

You do not need to file claims for treatment provided by a network provider or preferred care provider. If you use a non-network provider or non-preferred care provider, you will need to file an itemized written claim along with a copy of the bill from your provider for the payment of Covered Medical Expenses using the applicable Claims Administrator's claim form. Claim forms are available from the Claim Administrator's website or by contacting the Claims Administrator directly. A claim for benefits is treated as filed on the date it is received by the appropriate Claims Administrator. You 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.

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 generally has delegated responsibility for reviewing and deciding claims for benefits to the Claims Administrators. Respective decisions by the Claims Administrator and the Plan Administrator will be conclusive and binding on all parties and not subject to further review, except as required by law.

COORDINATION OF BENEFITS AND SUBROGATION

The Plan coordinates benefits among all group plans and insurance arrangements with a Covered Person to prevent duplication of medical 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 Medical Expenses. When a Covered Person is covered by the Plan and another group health 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. Except for the Cyro plan A option, 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 your negotiated charge or usual and reasonable or allowable amount charge, as defined under each plan. 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.

This Plan coordinates payment of medical 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 similar benefit plans that do 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 the coordination of benefits, the rules establishing the order of benefit determination are as follows unless such certificate or booklet provides for a differing order:

- 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 an employee whose date of birth occurs earlier in a Calendar Year will be primary to a plan that covers such person as a dependent of an employee whose date of birth occurs later in a Calendar Year (only month and day of birth, not year, will be reviewed in this case).
- 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 medical 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 or retired employee, or as a dependent of such an employee, will be secondary to any plan that covers such person as an active employee or as a dependent of such an active employee.

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.

Coordination Payments and Reimbursements

In accordance with these coordination of benefits provisions, whenever payments that should have been made under this Plan 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.

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 Retiree; (ii) if the person is a Dependent, the Dependent and the Retiree 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.

When medical 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.

Other Limitations

Generally, this Plan pays secondary to Medicare. If Medicare is the primary payer, benefit payments under the Plan for covered services will be reduced by benefits that could be paid by Part A and Part B of Medicare. This will apply even if you are eligible for Medicare but failed to enroll or maintain Medicare eligibility. For Retirees covered under the Cyro plan A, the Plan will pay up to 100% after Medicare pays their portion.

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.

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.

Subrogation and Right of Reimbursement

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 medical expenses by another person, plan, or entity, whether you request this payment or not, the Plan has the right to reduce its payments to you or your service providers accordingly, so that the Plan does not pay for amounts you would otherwise owe for your share of Covered Medical 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 medical 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.

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 payment due to fault or negligence by you or a third party.

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 the 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.

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 Employee, 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.

YOUR BENEFITS AND MEDICARE

Medicare is the federal government's health insurance program that covers people age 65 or older, some disabled people under age 65, and certain people with end-stage renal disease. Medicare has four parts:

- **Medicare Part A** (Hospital Insurance) helps pay for the costs of Hospitals, certain Skilled Nursing Facilities, Hospice Care and certain home health care.
- **Medicare Part B** (Medicare Insurance) covers doctors' fees and most outpatient hospital services and medical supplies.
- **Medicare Part C** (also known as Medicare Advantage) are health plan options that are part of the Medicare program. If you join one of these plans, you

generally get all your Medicare-covered health care through that plan. Part C coverage can include prescription drug coverage.

- **Medicare Part D** is a voluntary outpatient prescription drug benefit insurance program that covers both brand name and generic drugs at designated pharmacies. Medicare prescription drug plans provide at least a standard level of coverage set by Medicare.

Enrolling in Medicare

If you are eligible for Medicare, it is your responsibility to enroll (and ensure your covered Medicare-eligible Dependents enroll) for Medicare with your local social security office. If you or a covered Dependent is Medicare eligible and choses to continue Plan coverage, Medicare Parts A and B will be considered the primary insurance, and the Plan will only pay as a secondary insurer. In other words, the Plan will reduce its benefits by the amount Medicare paid, or would have paid, as the primary payer for the same expenses.

For Medicare Part D coverage, different rules apply for different Retirees.

- If you are a Cyro Retiree, then your pharmacy coverage under the Plan is considered “creditable”. So a Cyro Retiree can enroll in Medicare prescription drug coverage at a later time and does not need to enroll in Medicare Part D when first eligible. Also, if you choose to enroll in Medicare Part D, you are not eligible for prescription drug coverage under this Plan.
- For all other Retirees, your pharmacy coverage under the Plan is considered “non-creditable.” So if you or your Dependent do not enroll in Medicare Part D coverage when first eligible, then that Covered Person pays a penalty for late Part D enrollment every month during his or her lifetime.

For Covered Persons who are eligible for Medicare, Retiree medical coverage generally is available only under the BCBS of AL Traditional Choice coverage option, unless you are a Cyro, Oil Additives, Lockland, or Piscataway union Retiree. Accordingly, after becoming eligible for Medicare, Retirees will be required to switch to the post-65 Retiree coverage available to them. Medicare-eligible Retirees and covered Medical-eligible Dependents should receive a Medicare Benefit Election form two months prior to becoming eligible for Medicare. If you do not automatically receive the form, contact the Mercer Retiree Service Center at 1 855-684-6628.

To continue Plan coverage once you become eligible for Medicare, you must enroll in your available post-65 Retiree medical coverage option. You must complete the Medicare Benefit Election form and submit this form to the Mercer Retiree Service Center. If you do not move to your appropriate Medicare-eligible medical coverage option after you become eligible for Medicare, you and your Dependents will be deemed to have waived Retiree coverage, and you and your Dependents will no longer be Covered Persons under the Plan.

Only Covered Persons who are eligible for Medicare will change their Retiree coverage option. Family members who are not Medicare-eligible may remain in their pre-age 65 coverage option, as described under the *Plan Coverage Options* section.

TERMINATION OF COVERAGE

A covered Retiree's participation in the Plan will terminate on the earliest of these dates:

- The date the Program terminates;
- The date the Plan terminates;
- The date the Retiree's coverage terminates under the terms of the Plan;
- The date the Retiree is no longer eligible for coverage under the Plan;
- The date of the Retiree's death;
- The date the Retiree cancels coverage under the Plan; or
- The last day for which the Retiree made any required contributions.

A covered Dependent's coverage under the Plan will terminate on the earliest of these dates:

- The date the Program terminates;
- The date the Plan terminates;
- The date the Retiree's coverage ends, unless the Retiree dies, the rules for continuing Dependent coverage apply under the *Medicare Eligible Retiree with Non-Medicare Dependents* section, or the continuation of coverage rules apply as described in the *COBRA Coverage* section;
- The last day for which the Retiree or Dependent made any required contributions;
- The date Dependent benefits under the Plan are terminated; or
- The last day of the calendar month in which a covered Dependent loses eligibility due to loss of dependency status, subject to continuation of coverage rules described below in the *COBRA* section.

If a Covered Person's coverage ends under the medical coverage, benefits will only be provided to end of the month of the date of cancellation.

Under certain circumstances, Covered Persons may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the *COBRA Coverage* section of this document.

COBRA COVERAGE

Generally a Spouse and Dependents are eligible for COBRA continuation coverage if one of the following occurs.

- The Retiree dies;
- The Retiree gets divorced or legally separated from his or her Spouse;
- A Dependent no longer meets the Plan's definition of a Dependent; or
- The commencement of bankruptcy proceedings by the Company.

The Spouse or Dependent generally is eligible for up to 36 months of COBRA continuation coverage after the above event occurs. However, if coverage under the Plan ends due to the Company's bankruptcy, then the Retiree also can elect COBRA continuation coverage until the Retiree's death. A Spouse, Dependent or Retiree who may elect COBRA coverage is called a qualified beneficiary.

Paying for COBRA Coverage

A qualified beneficiary who elects COBRA coverage (or on whose behalf such election is made) is required to make contributions not less frequently than monthly in the amounts and at the times specified by the COBRA Administrator. The amounts of such contributions will be determined by the Company from time to time in accordance with applicable law. To the extent permitted under law, the required contribution for continuation coverage will be 102% of the full cost of coverage under the Plan.

The initial contribution amount will take into account the period of continuation coverage that precedes the date of the COBRA election and must be paid in full no later than 45 days following the date of election. In other words, even though you have 60 days to elect COBRA, your continuation coverage will start retroactive to the date coverage would have otherwise been lost, and your first COBRA payment must include the cost of coverage for that time period. Subsequent contributions will be considered timely only if made by the qualified beneficiary no later than 30 days following the due date.

When COBRA Ends

COBRA coverage may terminate before the end of the maximum period for COBRA continuation coverage (described above) if:

- The Company no longer provides group health coverage to any of its employees or Retirees;
- Premiums for COBRA coverage are not paid on a timely basis; or
- A qualified beneficiary eligible for COBRA continuation coverage first becomes covered after the election of COBRA continuation coverage by:

- Another group plan that does not contain a pre-existing condition exclusion or limitation;
- Another group plan that contains a pre-existing condition exclusion or limitation that does not apply because of federal law; or
- A qualified beneficiary eligible for COBRA continuation coverage first becomes entitled to Medicare benefits under Title XVIII of the federal Social Security Act, after the election period of COBRA continuation coverage.

REHIRING A RETIREE

A Retiree who is rehired and becomes eligible for active coverage as an employee will have the option to enroll in the active medical plan under the Evonik Corporation Consolidated Welfare Benefits Program. Change to active employee status may change the medical coverage options available to you. If you transfer to the active Evonik welfare plan, upon subsequent retirement, you will again be eligible to participate in this Retiree Plan, but only if you started Retiree coverage under this Plan prior to your rehire. Further, your new eligibility and contributions under this Retiree Plan will be based upon your latest hire date and company you are rehired into.

ERISA AND ADMINISTRATIVE INFORMATION

The Company intends to continue the Plan indefinitely. However, the Company reserves the right (subject to collective bargaining agreements, where applicable) to amend, change, reduce, or terminate the Plan, the Program, and/or any benefit options that are part of the Plan, and to change the cost of coverage under the Plan, at any time and for any reason without prior notice to or consent of Covered Persons. To the extent permitted by law, amendments or modifications may be retroactive if necessary to meet legal requirements or for any other reason. Termination of the Plan or the Program will not affect claims for benefits incurred prior to the termination.

No employee, former employee, officer, or director of the Company, the Employer, or any affiliate has the authority to alter, vary, or modify the terms of the Plan except by means of an authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan or the Program will be binding upon the Plan, the Program, the Plan Administrator, the Company, or any Employer.

Plan Documents

This SPD summarizes the key features of the Plan. You can find complete details in the official Plan documents that legally govern the operation of the Plan. Covered Persons can review copies of the documents at any time during normal business hours in the Plan Administrator's office. If you are unable to examine these documents there, you should write to the Plan Administrator, specifying the documents you wish to review, to arrange to review the documents at your worksite. You may also request copies of the official Plan documents by writing to the Plan Administrator. You will be charged a reasonable fee for copies of the documents requested unless federal law requires that they be furnished without charge.

The Plan may change from time to time to comply with applicable law, including any rules or regulations issued by the Internal Revenue Service or the U.S. Department of Labor. If material changes are required to comply with the law, affected Covered Persons will be notified.

Responsibilities of Plan Administrator

The Plan is a benefit plan maintained by the Company. The Plan Administrator administers the Plan in accordance with its provisions and, where applicable, the provisions of ERISA and other applicable laws. The Plan Administrator is responsible for establishing the Plan's policies, practices, and procedures and for interpreting the Plan. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator has sole and complete discretionary authority to determine questions relating to eligibility for participation in the Plan. The Plan Administrator has delegated responsibility for reviewing and deciding claims for Plan benefits to the Claims Administrators. Respective decisions by the Claims Administrator and the Plan Administrator will be conclusive and binding on all parties and not subject to further review, except as required by law.

No Guarantees

Your participation in the Plan does not constitute an employment contract and does not expand your employment rights with the Company, your Employer, or any subsidiary or affiliate. Nothing in this Summary Plan Description says or implies that participation in the Plan is a guarantee of continued employment, nor is it a guarantee that contribution and benefit levels will remain unchanged in future years.

Uncashed Checks

If you are enrolled in a self-insured coverage option, any benefit payments or reimbursement made by check from the Claims Administrator, on behalf of the Plan, must be cashed within one year after it is issued. If any check for a benefit payable under Plan is not presented for payment within one year of the date of issue, the Plan will have no liability for the benefit payment, the amount of the check will be deemed a forfeiture, and no funds will escheat to any state. Therefore, it is important to keep the Plan Administrator informed of your current address and to timely deposit your benefits checks. If you misplace a benefit payment or reimbursement check, you may contact the appropriate Claims Administrator within one year of the original date of issue to request that the check be re-issued. If the one-year period has elapsed, checks cannot be re-issued.

Statement of ERISA Rights

As a participant in the Plan described in this document, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan participants will be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Program with the U.S. Department of Labor and available at the Public Disclosure Room of Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Program's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report, if applicable.
- Continue health coverage for yourself, your Spouse, or your other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and/or your Dependents have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation rights.

Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including the Company,

your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Appealing a Denied Claim

You may make a written claim for benefits with the appropriate Claims Administrator as described in this SPD. Routine requests for information regarding your benefits under the Plan and other similar inquiries will not be considered benefit "claims" that require processing under ERISA or the Plan's claims procedures. 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 appropriate Claims Administrator as described in the Program booklet for your Retiree benefit coverage.

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

Enforce Your ERISA Rights

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after completing the Plan's claim and appeal process, as outlined in the section above. You may not start legal action against the Plan, the Plan Administrator, the Claims Administrator, your Employer, or any other Plan fiduciary until you have completed the Plan's claim and appeal process (including external review by an independent third party, if available), and have received a final decision regarding your claim. You must start legal action to recover benefits under the at the time period outlined in your benefit booklet or certificate of coverage. In addition, if you disagree with the Plan decisions or lack thereof concerning QMSCO, you may file suit in federal court after completing the Plan's claim and appeal process.

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

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Claims Administrator or Plan Administrator, as appropriate. If you have any questions about this statement of your rights, or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT NOTICE FOR NON-ENGLISH SPEAKING EMPLOYEES

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, are capitalized. These defined terms apply only to the extent used in this SPD and may have a different meaning if used in the certificate of coverage or benefits booklet.

Calendar Year means January 1st through December 31st of the same year.

Claims Administrator means the entity identified for each Program and coverage option in the applicable Program SPD or booklet.

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

COBRA Administrator means the below entity.

PayFlex Systems USA, Inc.
P.O. Box 953374
St. Louis, MO 63195-33741
1-888-678-7835

Company means Evonik Corporation.

Covered Medical Expense means services or supplies for which a benefit is payable under the Plan.

Covered Person means a Retiree or Dependent 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.

Dependent means a covered Retiree's/Spouse and eligible child(ren), as set forth in the *Eligibility and Enrollment* section.

Employee means a person who is on the payroll of an 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 that 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. You may receive current information as to whether a particular company is an Employer by contacting the Plan Administrator

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.

HMO means a health maintenance organization.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Medicare means the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended. HMO

Plan means the Evonik Corporation Consolidated Retiree Welfare Benefits Program.

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

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

Program means the component benefit under the Evonik Corporation Consolidated Welfare Benefits Program.

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 Retiree. A QMCSO must comply with the requirements 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, a Retiree's 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. 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 this SPD.

Spouse means the Retiree's legal partner in marriage at the time of retirement to whom the Retiree is not legally separated or divorced. Spouse includes a same-sex spouse to whom the Retiree is legally married. Spouse does not include a Retiree's registered domestic partner, common law spouse, civil union partner, or other similar relationships recognized under state law. For any insured benefit, Spouse means the Retiree'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.

Years of Service means service as determined under the retirement plan under which the individual retired; however, if the Employee has a break in service, the Employee's eligibility for Retiree coverage is determined based on the Employee's rehire date.