Evonik Corporation
Vision Service Plan
Summary Plan Description (SPD)

SUMMARY PLAN DESCRIPTION

FOR

EMPLOYEES, LTD PARTICIPANTS AND CERTAIN RETIREES

(AND THEIR ELIGIBLE DEPENDENTS)

IN THE EVONIK CORPORATION VISION SERVICE PLAN

EFFECTIVE JANUARY 1, 2021

This document is the Summary Plan Description (SPD) for the Evonik Corporation Vision Plan (the Plan or the Vision Plan) for non-union and certain union Employees, former Employees receiving benefits under the Evonik Long Term Disability Program, and certain pre-65 Retirees who were initially hired by Oil Additives prior to 2017 and who meet certain age and service requirements (described in the Base Retiree SPD) (together "Covered Persons"). This SPD outlines the rights and benefits of Covered Persons and their Dependents and describes the major provisions of the Plan as in effect on January 1, 2021. This booklet, together with either the Evonik Active and LTD Base SPD or the Retiree Base SPD will constitute the entire SPD for the Vision Plan. Eligibility for the Vision Plan, as well as important legal information is located in the either the Evonik Active and LTD Base SPD or Retiree SPD. Vision Plan benefit details are in this booklet.

The Plan is a participating Plan under the Evonik Corporation Consolidated Welfare Benefits Program (the Program), sponsored by Evonik Corporation (the Company), if you are an Employee or are receiving benefits under the Evonik Long Term Disability Program. The Plan also is a participating Plan under the Evonik Corporation Consolidated Retiree Welfare Benefits Program (the Program) if you are an eligible Retiree. The Plan provides vision benefits to eligible Covered Persons of the Company and its participating Employer affiliates. You may check with Mercer Marketplace to verify that your employer is a participating Employer at **1-855-684-6628**, Monday through Friday, 7:00 am to 9:00 pm, ET.
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This SPD is intended to explain the terms of the Plan in non-technical, everyday language, but capitalized terms and phrases have specific meanings within the context of the Plan. These special capitalized terms are defined in the *Defined Terms* section at the end of this SPD. The Defined Terms section acts like a glossary.

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

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

GENERAL PLAN INFORMATION

Introduction

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

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

The coverage and benefit levels described in this document are subject to change. Please contact the Mercer Marketplace at 1-855-684-6628, Monday through Friday, 7:00 am to 9:00 pm, ET. to confirm cost and coverage information. Benefits under this Plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them.

VISION PLAN COVERAGE OPTION

The Vision Plan provides comprehensive coverage for many vision services and is offered to help Covered Persons pay for vision care.

The Plan allows you the flexibility to choose a participating Network Provider or a Non-Network Provider each time you need vision services. Network Providers agree to provide services to in-network Covered Persons at a reduced fee (Negotiated Charge). A Covered Person can receive benefits at a lower cost under the Plan by using a Network Provider. In order to maximize benefits Covered Persons should obtain vision care from a Network Provider and should ensure that the provider had obtained a benefit authorization prior to receiving services, as described below in *Benefit Authorization Needed to Receive Network Benefits*. Another advantage of using Network Providers is that there are no claim forms to submit. Your Network Provider will submit a claim to the Claims Administrator for payment and then bill you directly for any Copay that you must pay. If you use a vision service provider who is not a Network Provider, on the other hand, you will need to pay the vision service provider and then submit a claim for reimbursement. When you obtain care from a Network Provider, your out of pocket expenses will be lower than when you use a Non-Network Provider.

In order to locate a Network Provider, you can visit the VSP website at www.vsp.com or contact VSP at **1-800-877-7195**. No insurance cards are issued; therefore, you need to provide the last four digits of your Social Security Number to your provider as your member number. Your Network Provider will need to verify your eligibility for benefits and obtain a benefit authorization before your appointment.

Below are the highlights of the VSP vision coverage option.

SUMMARY OF PLAN BENEFITS

Feature	If You Use A Network Provider	If You Use Any Non-Network Provider
Vision Exam (non-Contact Lens Exam) 1 exam in a consecutive 12-month period.	100% of Negotiated Charge	Plan pays up to $50.00 You are responsible for amounts greater than $50.00.
Frames 1 frame in a consecutive 12-month period.	Plan pays up to $150.00 plus a 20% discount off any amount over the $150 Allowance. ($10 Copay also applies if purchasing frames only). You are responsible for amounts greater than the Plan pays.	Plan pays up to $70.00 You are responsible for amounts greater than $70.00. ($10 Copay also applies if purchasing frames only)
Prescription Lenses - Once in a consecutive 12-month period –		
Single	100% of Negotiated Charge after $10 Copay	Plan pays up to $50.00 You are responsible for amounts greater than $50.00.
Lined Bifocal	100% of Negotiated Charge after	Plan pays up to $75.00

	$10 Copay	You are responsible for amounts greater than $75.00.
Lined Trifocal	100% of Negotiated Charge after $10 Copay	Plan pays up to $100.00 You are responsible for amounts greater than $100.00.
Lenticular	100% of Negotiated Charge after $10 Copay	Plan pays up to $125.00 You are responsible for amounts greater than $125.00.
Feature	**If You Use A Network Provider**	**If You Use Any Non-Network Provider**
Standard Progressive	100% of Negotiated Charge after $10 Copay	Plan pays up to $75.00 You are responsible for amounts greater than $75.00.
Premium Progressive	100% of Negotiated Charge after $80.00 - $90.00 Copay (range based on type of premium progressive lens)	Plan pays up to $75.00 You are responsible for amounts greater than $75.00.
Custom Progressive	100% of Negotiated Charge after $120.00 - $160.00 Copay (amount based on type of custom progressive lens)	Plan pays up to $75.00 You are responsible for amounts greater than $75.00.
Tinted/Photochromic (optional)	100% of Negotiated Charge if purchasing lenses	Plan pays up to $5.00
Contacts - In Lieu of Glasses - Once in a consecutive 12-month period		
Contacts - Prescription Lenses and Exam - Medically Necessary	100% of Negotiated Charge after $10 Copay	Plan pays up to $210.00 You are responsible for amounts greater than $210.00.
Elective (not medically necessary) - Prescription Lenses and Exam	$150.00 Allowance for contact Prescription Lenses and the contact lens exam (fitting and evaluation). Copay is up to $60.	Plan pays up to $105 You are responsible for amounts greater than $105.00.
Specialty Eyecare Services		
Diabetic EyeCare	100% after $20.00 Copay for Covered Persons with Type 1 diabetes	Not applicable
Low Vision – Maximum allowable for all Low Vision Benefits $1,000 every 2 years		
Supplementary Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)	100% of Negotiated Charge	Plan pays up to $125.00, You are responsible for amounts greater than $125.00.
Low Vision Benefit – Supplementary Care Aids	Plan pays 75% of cost, You are responsible for amounts greater than 75%.	Plan pays up to 75% of cost, You are responsible for amounts greater than 75%.
Extra Discounts and Savings		
Laser Vision Care℠ (age 18 and older)	For preoperative and postoperative care - average 15% off the regular price or 5% off the promotional Price. Discounts only available from contracted facilities.	Not applicable

Glasses and Sunglasses	• 30% off additional glasses and sunglasses, including lens options, from the same VSP Provider on the same day as your vision exam; or • 20% off from any Network Provider within 12 months of your last vision exam	Not applicable
Retinal Screening	• No more than a $39 copay on routine retinal screening as an enhancement to the Well/Vision Exam.	Not applicable

COVERED VISION EXPENSES

The following is a list of Covered Vision Expenses under the VSP vision option. All services are subject to the Plan's maximum Allowance, age, and frequency limits. Refer to the *General Exclusion Section* for information on vision expenses that are not covered under the Plan.

Vision Exams (non-Contact Lens Exams). The Plan will pay 100% of the Negotiated Charge if you use a Network Provider. When you use a Non-Network Provider, the Plan will pay up to $50.00. If the Non-Network Provider's actual charge for the exam is greater than $50.00, you must pay the difference. Vision exams are covered once in a consecutive 12-month period.

Contact Exam and Contact Prescription Lenses. The Plan pays 100% of the Negotiated Charge after you pay a $10.00 Copay for medically necessary contacts. When you use a Non-Network Provider for medically necessary contacts, the Plan will pay up to $210.00 for the contact exam and the contact Prescription Lenses. Whether in-network or out-of-network if the actual charge for the exam and the contact Prescription Lenses is greater than the $210.00 Allowance, you must pay the difference.

The Plan pays up to a $150.00 Allowance for non-medically necessary contact Prescription Lenses and the contact lens exam that includes the fitting and evaluation with a 15% discount on the exam if you use a Network Provider. The Allowance only applies if you elect to receive Plan benefits for contact Prescription Lenses instead of glasses. When you use a Non-Network Provider, the Plan will pay up to $105.00 for the non-medically necessary contact exam and the contact Prescription Lenses. Whether in-network or out-of-network if the actual charge for the exam and the contact Prescription Lenses is greater than the $150.00 Allowance, you must pay the difference.

Contact exam and contact Prescription Lenses are covered once in a consecutive 12-month period.

Whether you use a Network Provider or a Non-Network Provider, benefits for contact exams and contact Prescription Lenses require pre-approval from VSP. Contact VSP at

1-800-877-7195 for approval. If you use a Network Provider, your provider should request the approval on your behalf.

Frames. The Plan pays up to a $150.00 Allowance for the cost of the frames, and you receive a 20% discount off any amount over the $150.00 Allowance if you use a Network Provider. When you use a Non-Network Provider, the Plan will pay up to $70.00. Whether in-network or out-of-network, if the actual charge for the frames you select is greater than the Allowance, you must pay the difference. Frames are covered once in a consecutive 12-month period.

If you purchase frames only (not with Prescription Lenses), the Plan will pay 100% after you pay a $10.00 Copay if you use a Network or Non-Network Provider, up to the Allowance.

If you have had laser correction surgery, you can also use your VSP frame Allowance toward the cost of non-prescription sunglasses from any Network Provider.

Some brands of spectacle frames may be unavailable for purchase under the Plan or may be subject to additional limitations. You may obtain details regarding frame brand availability from their Network Provider or by calling VSP's Customer Care Division at **(800) 877-7195**.

Prescription Lenses. The Plan pays 100% of the Negotiated Charge after you pay a $10.00 Copay for single, bifocal, trifocal or standard progressive Prescription Lenses, including photochromic and tinted lenses if you use a Network Provider. If you use a Non-Network Provider, after you pay a $10.00 Copay, the Plan will pay up to $50.00 for single vision; up to $75.00 for lined bifocal, up to $100.00 for lined trifocal, and up to $75 for standard progressive Prescription Lenses. If the Non-Network Provider's actual charge for the Prescription Lenses is greater than the Allowance, you must pay the difference. Prescription Lenses (of any kind) are covered once in a consecutive 12-month period.

The Plan also pays 100% of the Negotiated Charge for premium and custom progressive Prescription Lenses after a $80-$100 Copay for premium, and $120.00-$160 Copay for custom progressive Prescription Lenses if you use a Network Provider. The premium and custom progressive Prescription Lenses come in different categories. The dollar amount range is based on the category of Prescription Lenses that you choose. If you use a Non-Network Provider, premium and custom progressive Prescription Lenses are covered at the trifocal Prescription Lens amount of $100.00. If the Non-Network Provider's actual charge for the Prescription Lenses is greater than the Allowance, you must pay the difference. Prescription Lenses (of any kind) are covered once in a consecutive 12-month period.

Low Vision Benefit. The Plan provides supplementary testing and care aids benefits if you have severe visual problems that are not correctable with regular lenses. The Plan pays 100% of the Negotiated Charge for a complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the

prescription of corrective eyewear or vision aids where indicated. If you use a Non-Network Provider, the Plan will pay up to $120.00 for supplementary testing. If the Non-Network Provider's actual charge for the Prescription Lenses is greater than the $120.00 maximum, you must pay the difference. The Plan also pays for 75% of the cost of low vision aids. The Plan will pay a maximum of $1000.00 for low vision benefits every two years.

Laser VisionCare℠ Program. The Plan offers laser correct surgery at a reduced price only from VSP-approved laser surgeons and centers. Covered Persons receive a discount on preoperative and postoperative care. The average savings is 15% off the regular price or 5% off the promotional price from participating facilities.

A Covered Person may be eligible for laser correction surgery if he/she is nearsighted, farsighted, or has astigmatism and is at least 18 years old and in good health with no eye diseases. You should make an appointment with a Network Provider for a screening and consultation to find out if you qualify for laser correction surgery. If you qualify and decide to have laser correction surgery, the Network Provider will make arrangements with one of VSP's approved laser centers. In order to locate a Laser VIsionCare Provider, you can visit the VSP website at www.vsp.com or contact VSP at **1-800-877-7195**.

VSP's Laser VisionCare program covers the following two types of surgery: CustomLASIK and Conventional LASIK.

DIABETIC EYECARE

The Diabetic Eyecare Plus Program (“DEP Plus”) is intended to be a supplement to Covered Person's group medical plan. Providers will first submit a claim to Covered Person's group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as “Coordination of Benefits” or “COB." Please refer to the Coordination of Benefits section of Covered Person’s Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- “floating” spots

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- rubeosis

Referrals for Diabetic EyeCare

If Covered Person's Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Person receive the appropriate level of care for their presenting condition. *Covered Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.*

Covered Services for Diabetic EyeCare

- Eye Examination: Covered in full after a Copayment of $20.00.

- Special Ophthalmological Services**:** Covered in Full.

Exclusions and Limitations for Diabetic Eyecare

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Person upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

Diabetic Eyecare – Services Not Covered

1. Services and/or materials not specifically included in this Rider as Plan Benefits.
2. Frames, lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

Diabetic Eyecare Program Definitions

Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.

ELIGIBILITY AUTHORIZATION TO RECEIVE NETWORK BENEFITS

Covered Vision Expenses will only be covered as Network Charge if you receive services from a Network Provider who has obtained an eligibility authorization from VSP prior to providing services to you. To receive Network Charges, when you schedule an appointment with a Network Provider, you should identify yourself as a participant eligible for VSP member benefits. You will need to provide the last four digits of your Social Security Number to your provider to confirm your eligibility. The Network Provider will request an authorization from VSP before your appointment. If you receive Covered Vision Expenses from a Network Provider without an eligibility authorization, then the provider will be considered a Non-Network Provider and benefits will be paid at the Non-Network level. Therefore, it is important to confirm with your provider that you have an eligibility authorization before you incur any expenses**.**

This Plan is designed to cover visual needs rather than cosmetic materials. When a Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed Prescription Lenses or frames, and the Covered Person will pay the additional costs for the options:

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.

- Oversize lenses.
- Polycarbonate lenses.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan Allowance.
- Contact lenses (except as noted elsewhere herein).

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (less than a ± .50 diopter power);
- Two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination, or corrective eyewear, that is required by your employer for employment (for example, Safety Glasses);
- Corrective vision services, treatments, and materials of an experimental nature;
- Costs for services and/or materials above Plan Allowances; and
- Services and/or materials not listed above as Covered Vision Expenses

FILING A BENEFIT CLAIM

This portion of the SPD explains how to file a claim for benefits under the Plan.

Either a Covered Person or his or her authorized representative may file claims for benefits under the Plan and act as the claimant. If you wish to designate someone as your authorized representative, you must contact the Claims Administrator (VSP) to obtain a form and complete the form as instructed. If a person is not properly designated as your authorized representative, the Claims Administrator will not be able to deal with him or her in connection with the exercise of your rights under the Plan. All communications from the Claims Administrator will be directed to the Covered Person claimant or his or her authorized representative.

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

Filing an Initial Benefits Claim

You do not need to file claims for treatment provided by a VSP Network Provider. If you use a Non-Network Provider, you will need to file an itemized written claim for the payment of Covered Vision Expenses, using the Claims Administrator's claim form.

Claim forms can be found on the Claims Administrator's website or by calling the Claims Administrator directly. A claim for benefits is treated as filed on the date it is received by the Claims Administrator. A Covered Person must comply with these procedures and provide the specified information in order for the claim to be considered filed with the Claims Administrator. A separate claim form must be filed for each Covered Person.

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

All claims for services received must be submitted by Covered Persons to VSP within one hundred eighty (180) days of the date of service. VSP reserves the right to reject such claims which are filed more than one hundred eighty (180) days after the date of service. Failure to submit a claim within one hundred eighty (180) days, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as was reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date. All claims should be sent to the following addresses.

Claim forms can be found on **www.vsp.com**.

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

If Your Claim is Denied or Partially Denied

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

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

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

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

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

Appealing a Denied Claim

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

An appeal of an Adverse Benefit Determination must be made within **180 days** after you receive notification of the Claims Administrator's Adverse Benefit Determination. You must submit any appeal of an Adverse Benefit Determination to the Claims Administrator at the below address:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
+1 (800) 877-7195

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

Decisions on Appeal

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

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

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

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

Notice of Decision on Appeal

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

- the specific reason or reasons for the Adverse Benefit Determination;

- specific reference to pertinent Plan provisions on which the Adverse Benefit Determination was based;
- a statement of your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- a statement of your right to bring a civil action under ERISA Section 502(a) once the Plan's claims and appeals procedures (as described in this SPD) have been exhausted;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- if the Adverse Benefit Determination is based on a medically necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Scope of Review of Appealed Claims

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

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

If Your Claim is Denied on Final Appeal

No action at law or in equity may be brought to recover under this Plan until the claims and appeals procedures, as described above, have been exhausted, and the benefits requested in the final appeal have been denied in whole or in part. **Any legal action brought against the Plan must be brought by the earliest of the following: (i) 90 days from the date of the final Adverse Benefit Determination after all appeals and reviews have been utilized and exhausted, (ii) three years after the date that the service or treatment at issue in the legal action was provided by a Physician, Hospital, or other health care provider, or (iii) the statutory deadline for filing a claim or lawsuit with respect to the Plan benefits at issue in the judicial**

proceeding as determined by applying the most analogous statute of limitations for the State of Delaware. If you do not file a legal action within this time period, you lose any rights to bring such an action against the Plan or its fiduciaries. If you decide to pursue any legal action relating to your claim, the evidence that you may present in your case will be strictly limited to the documents, information, and other evidence timely presented to the designated Claims Administrator, the Plan Administrator, and any external reviewer, if applicable as described above.

FINAL AND BINDING DECISIONS

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

COORDINATION OF BENEFITS

The Plan coordinates benefits from all group plans and certain insurance arrangements covering a Covered Person to prevent duplication of vision 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 Vision Expenses. When a Covered Person is covered by the Plan and another plan, the plans will coordinate benefits when a claim is received.

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

Other Plans

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

- group or group-type plans, including franchise or blanket benefit plans;
- group practice and other group prepayment plans;

- other plans required or provided by law (this does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination); and
- no-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Order of Benefit Determination

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

- A plan that covers a person other than as a dependent will be primary to a plan that covers such person as a dependent.
- A plan that covers a person as a dependent of 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 vision 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.

Payment to Other Organizations

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

Reimbursement

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

Medicare Limitation

Generally, this Plan pays primary to Medicare, even if you (or your Dependent) have reached age 65. However, if you are entitled to Medicare due to end-stage renal disease, Medicare will become the primary plan after 30 months of Medicare entitlement. 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 eligibility.

Other Limitations

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

Right to Receive and Release Necessary Information

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

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

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

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 vision expenses

by another person, plan, or entity, whether you request payment or not, this Plan has the right to reduce its payments accordingly so that the Plan does not pay for amounts you would otherwise owe for your share Covered Vision 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 vision 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 of payment due to your or any third party's fault or negligence.

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

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

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 Retiree, 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.

TERMINATION OF COVERAGE

When Coverage Ends

A Covered Person'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 Covered Person's coverage terminates under the terms of the Plan;
- The date the Covered Person is no longer eligible for coverage under the Plan;
- The date of the Covered Person's death;
- The date Covered Person cancels vision coverage under the Plan; or
- The last day for which the Covered Person made 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 Covered Person's coverage ends, subject to continuation of coverage rules described below in the *COBRA Continuation* section.
- The last day for which the Covered Person or Dependent made required contributions;
- The date the Plan no longer offers coverage for Dependents;
- The date Dependent benefits under the Plan are terminated;
- The date the Dependent's coverage terminates under the terms of the Plan;
- 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 Continuation* section;
- The date the Covered Person cancels Dependent vision coverage under the Plan; or
- The date of the Covered Person's death.

The Plan will not pay for vision benefits for services or supplies that are furnished after a Covered Person's coverage ends. This is the case even if the Claims Administrator has predetermined benefits for a treatment program that was submitted before the date the coverage ended.

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 section of this document entitled *COBRA Continuation*.

Continuation of Benefits During Periods of Disability and Leave of Absence

A covered Employee continues to participate in the Plan for a limited time if he or she ceases to be actively at work and qualifies for a STD Benefit under the STD Procedure. This continuation of coverage ends on the day the person is no longer eligible for STD

Benefits. The benefits continued during the period of disability will be the same level of benefits that were in force on the last day the person was actively at work as an Employee. However, if benefits are changed or reduced for other active Employees of the Employer who are not on a disability leave, the same benefit changes or reductions will also apply to the disabled Employee.

If you take an approved leave of absence, coverage will generally continue unchanged during that leave of absence unless the Employee changes his or her election as a result of a Qualified Change in Coverage event (as described in the Active and LTD Base SPD or the Retiree Base SPD). During a paid leave of absence, deductions continue as they would if the Employee were at work. If an Employee is on an unpaid leave of absence, he or she would be required to pay monthly premiums on an after-tax basis during the unpaid leave.

Coverage During a Family and Medical Leave (FMLA Leave)

Regardless of the established leave policies mentioned above, this Plan and the Program will at all times comply with the FMLA and the applicable regulations issued by the U.S. Department of Labor. During any FMLA Leave, whether (i) for your own serious health condition, (ii) to care for family members, (iii) after the birth or adoption of child, (iv) for certain covered activities if your Spouse, child, or parent is on active duty (or has been notified of a call or order to active duty) in the U.S. Armed Forces and is deployed to a foreign country, (v) to care for your Spouse, child, parent, or next of kin who is a covered service member of the U.S. Armed Forces who is injured in the line of active duty, or (vi) for other reasons designated by the FMLA, the Employer will maintain benefits under this Plan on the same conditions as those that apply to similarly-situated active Employees. You have to pay for these benefits yourself at the same rate as you did during active employment. However, you are also permitted to terminate vision coverage during an FMLA Leave. In that event, deductions will be reinstated if you return to work in accordance with the terms of the FMLA Leave. Deductions will be reinstated only if the person(s) had benefits under this Plan when the FMLA Leave started, and deductions will be reinstated to the same level and extent that applied when those benefits terminated. Contact your Human Resources department for more information.

Employees on Military Leave

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Re-employment Rights Act (“USERRA”). These rights apply only to Employees and Dependents covered under the Plan before the Employee leaves for military service. Contact your Human Resources department for more information.

Rehiring a Terminated Employee

A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements.

For Information About COBRA

For information about continuing benefits under COBRA, refer to either Active and LTD Base SPD, or Retiree Base SPD based on your status or contact the COBRA Administrator:

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

IMPORTANT NOTICE FOR SPANISH 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, will be capitalized. These defined terms apply only to the extent used in this SPD.

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

Allowance means the amount VSP provides toward the cost of your eyeware.

Claims Administrator means VSP.

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

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

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

Company means Evonik Corporation.

Copay means a fee charged to a Covered Person which represents a portion of the applicable Covered Vision Expense. Plan Copays are listed in the Summary of Plan Benefits chart.

Covered Person means an Employee or individuals who are receiving long term disability or former Employees who meet the definition of Retiree under the Base Retiree SPD and are eligible for vision coverage,

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

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

Employee means a person employed by the Employer.

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

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

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

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

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

LASIK is a procedure where after a flap of cornea is cut with a surgical device called a microkeratome and folded back, a computer-programmed excimer laser reshapes the cornea and the flap is replaced.

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

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

Network Providers are vision services providers who have entered into an agreement with the Plan to charge reduced fees to persons covered under the Plan so that the Plan can reimburse or discount a higher percentage or amount of the vision services provider's fees.

Non-Network Providers are vision services providers who have not entered into an agreement with the Plan to charge reduced fees to persons covered under the Plan.

Plan means the vision benefits provided under the Evonik Corporation Vision Plan, which is a welfare benefits plan for certain eligible Employees of Evonik Corporation and the other participating Employers as described herein.

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

Plan Sponsor means the Company, which directs the establishment of the Plan and the Program and appoints the administrator of the Plan.

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

Prescription Lens(es) means corrective lenses to provide vision correction to a Covered Person's specific needs. If an examination indicates that corrective lenses are appropriate, the prescriber generally provides the patient with an eyewear prescription at the conclusion of the exam.

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

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

Safety Glasses means prescription glasses that are certified according to ANSI and OSHA requirements.

Spouse means the Covered Person's legal spouse to whom the Covered Person is not legally separated or divorced. Spouse includes a same-sex spouse to whom the Covered Person is legally married. Spouse does not include a Covered Person's registered domestic partner, civil union partner, or other similar relationships recognized under state law.

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

STD Procedure - The Evonik Short Term Disability Procedure

VSP means the Vision Service Plan.

Waiting Period means the number of days after the first day of employment as an Employee that must pass before you are eligible to enroll and participate in this Plan.