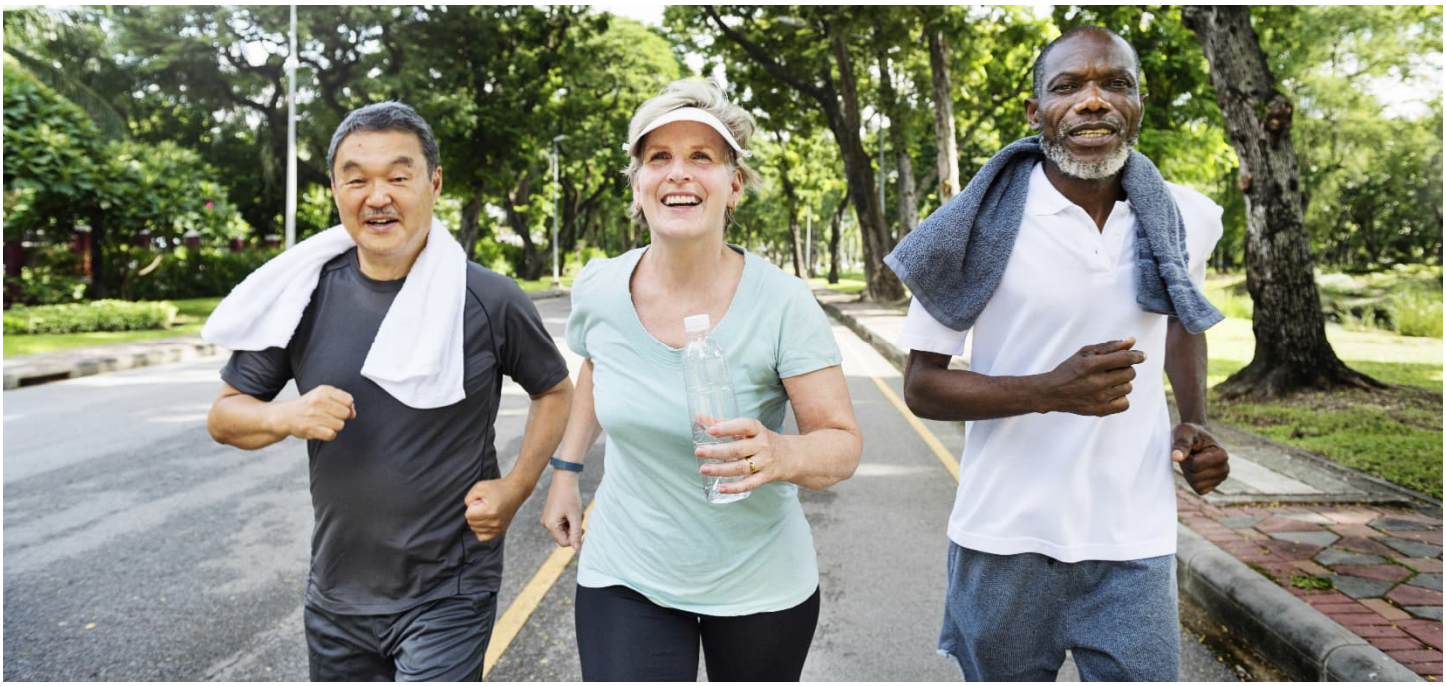
2023 Annual Enrollment Brochure for Cyro Pre-65 Retirees

Get Ready to Enroll: October 21 – November 4, 2022

EVONIK
Leading Beyond Chemistry

Welcome to 2023 Annual Enrollment

Annual Enrollment is your once-a-year opportunity to review your Cyro Benefits Program options and choose the benefits that best meet your needs and the needs of your family. The Annual Enrollment period for 2023 Evonik benefits begins on October 21, 2022 and ends on November 4, 2022.



What's New for 2023

- While Evonik and the vast majority of our retirees had no cost increases in 2022, effective January 1, 2023, medical premiums and contributions, if applicable, for Cyro's pre-65 medical plans (Blue Cross Blue Shield) will be increasing 9.4%. Please see your enrollment form which details your new contributions.
- The Choice Plus HSA medical plan's deductibles and out-of-pocket maximums will increase for 2023 per IRS rules, by $100 (individual) and $200 (family). The Choice Plus Value Plan will not be affected by this change.
- Health Savings Account (HSA) annual contribution limits will increase by $200 (individual) and $450 (family), allowing you to save more to pay for eligible health care expenses and earn great tax benefits if you are enrolled in one of the high deductible plans.
- We're raising the coinsurance benefit the plan pays for out-of-network behavioral health care office visits (for mental health and substance abuse). This will apply to the Choice Plus and Choice Plus Value plans. See "Blue Cross Blue Shield Plans Administered by BCBS of Alabama" on page 7 for more details.

Making Benefit Changes for 2023

It's always a good idea to closely review your benefits needs each year. We encourage you to consider the benefits you used in 2022 and estimate how these needs may change in 2023, especially because the medical plan contributions will increase for 2023.

If you decide not to make any changes, your 2022 benefits will carry forward to next year at 2023 contribution rates, if applicable.

If you or your dependent turns age 65 in 2023, the medical plan offered will change for the individual turning 65. Additionally, your contributions will change.

Be Sure Your Dependents Are Eligible for Coverage

Dependents enrolled for coverage — both newly added and those already enrolled — must meet the eligibility requirements to be covered by Evonik benefits.

Dependent Eligibility Verification

If you are enrolling children as new dependents for 2023, first be sure they meet the eligibility requirements described below. Any newly added children will be verified during the enrollment process before they can be covered under any plan. Mercer, our benefits administrator, will reach out to you to request certain dependent verification documents. You will be asked to provide proof of your child's eligibility (for example, a birth certificate), which will be due within 31 days of your benefit election date. Coverage for your newly added child will not begin until eligibility is verified.

Dependents approved during the Dependent Verification Audit do not need to resubmit verification for those dependents.

The Company reserves the right to verify dependent status periodically and may request proof of eligibility from you at any time. Any misrepresentation of dependent information will be considered a deliberate falsification of Company records. You may also be held financially responsible to repay any claims the plan paid on your behalf for the improperly covered person.

Who Qualifies as an Eligible Dependent?

Under the Evonik Retiree Medical Plan, your eligible dependents are your:

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

Note that you may not enroll as a dependent / spouse a new legal partner in marriage who was not your legal partner at the time you retired from Evonik.

If you have any questions about whether a dependent is eligible for coverage, please contact Mercer's Retiree Service Center, +1 855-684-6628, Monday through Friday, from 8:00 am to 9:00 pm ET.

Retiree Benefits Administration Provided by Mercer

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

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

Benefit Resources

Retiree Benefits Website

You have 24/7 access to Mercer's Retiree Benefits website, www.evonikretireebenefits.com.

The Retiree Benefits website provides convenient access to a variety of helpful online resources, including:

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

Retiree Service Center

When you call the Retiree Service Center at Mercer at +1 855-684-6628, you can receive assistance with the following questions:

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

The Retiree Service Center is available to assist you Monday through Friday, from 8:00 am to 9:00 pm ET.

How to Change Your Benefit Elections

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

Enrollment in your 2023 retirement benefits is easy, and we are providing you with several ways to enroll, including:

- Mail: Complete the enclosed enrollment form and return it to Mercer in the envelope provided. Note, enrollment forms must be postmarked by Friday, November 4; or
- Online: Access the Evonik Retiree Benefits website at www.evonikretireebenefits.com and click on the "Enroll Now" button for Pre-65 retirees. The Enrollment feature of the website will be available beginning October 21. You will need your Certificate Number (beginning with 26019) located on the enclosed enrollment form. If you don't have your Certificate number, call the Retiree Service Center for assistance. The Mercer representative will ask a series of privacy questions to validate your identity.
- Phone: Call the Retiree Service Center at +1 855-684-6628, Monday through Friday, from 8:00 am to 9:00 pm ET. Representatives can take your enrollment information over the telephone.

If you elect to enroll online or through the Retiree Service Center, you must complete your enrollment by Friday, November 4.

Mercer will process your enrollment and send your elections to BCBS of AL. New enrollees will receive a Medical ID card.

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

Using My Account on the Retiree Benefits Website

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

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

My Account can be accessed by clicking on the My Account button at EvonikRetireeBenefits.com or visiting www.mercermyaccount.com. To register your "My Account," you will need the following:

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

How do I contact the Retiree Service Center?

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

Health Advocacy

Included with your medical coverage, you and your dependents have access to Health Advocacy services provided by Health Advocate. Health Advocate is an independent resource for you to use to help navigate the often complex health care system.

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

Health Advocate is there to help our retirees and their dependents with a wide range of issues. Your Personal Health Advocate can:

Clinical

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

Administrative Support

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

Health Advocate can be reached at +1 866-695-8622. Health Advocate services can be accessed 24/7. Normal hours of operation are Monday through Friday, from 8:00 am to 10:00 pm ET. Staff is available for assistance after hours and on weekends. In a crisis, help is available 24/7.

Your 2023 Medical Plan Options

We recognize that some retirees prefer to pay more in out-of-pocket expenses when they use the plan and have lower contributions, while others prefer to pay lower out-of-pocket expenses when they use the plan and have higher contributions. Given these different needs, you will have a choice of three Pre 65 medical plan options for 2023:

- BCBS – Cyro Pre-65 plan
- BCBS – Choice Plus HSA*
- BCBS – Choice Plus Value HSA*

* For information on how a Health Savings Account (HSA) works, eligibility for an HSA and IRS annual contributions, refer to "Health Savings Accounts (HSAs) Offered Under the Choice Plus HSA Plan and Choice Plus Value HSA Plan" on page 12.

Find Out if Your Providers Are Part of the BCBS Network

You can use the online BCBS of AL provider finder at AlabamaBlue.com. To access the correct network, enter contract prefix "DHC" or select "BlueCard PPO Network" under "Select All Networks" to locate providers. You can also call BCBS of AL's call center at +1 833-994-0014 to find out whether your current providers are in the BCBS network.

Contributions Are Increasing for 2023

Please review your enrollment form within this packet for the 2023 contributions for each of the BCBS medical options. Your contribution costs and potential savings will depend on your specific medical option selected. Like many companies, the combined effect of inflation and general health care cost increases has made it necessary to make this decision.

Medical Plan Comparison

The chart that follows shows general coverage information for available pre-65 retiree plans. Remember, as health care costs continue to increase, it is important to shop for health care services like you would for the purchase of other major goods and services. We encourage you to familiarize yourself with the cost of medical services you receive and to use in-network providers when possible. Maintaining a healthy lifestyle and taking advantage of preventive care services may also help you to keep down your medical costs.

See below for a summary of all of your 2023 Medical Options and their design highlights.

Blue Cross Blue Shield Plans Administered by BCBS of Alabama

	Cyro Pre-65 (BCBS of AL)		Choice Plus HSA (BCBS of AL)		Choice Plus Value HSA (BCBS of AL)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible						
*Single**	$450	$450	$1,500	$1,500	$2,850	$2,850
*Two-Person**	N/A	N/A	N/A	N/A	N/A	N/A
*Family**	$900	$900	$3,000	$3,000	$5,700	$5,700
Annual Out-of-Pocket Maximum (Includes Deductible)						
*Single**	$1,750	$1,750	$3,300	$3,300	$5,500	$5,500
Two-Person	N/A	N/A	N/A	N/A	N/A	N/A
*Family**	$3,500	$3,500	$4,800	$4,800	$11,000	$11,000
Lifetime Maximum Per Person	$750,000		N/A		N/A	
Preventive Care	Plan pays 100%		Plan pays 100%	Plan pays 80%	Plan pays 100%	Plan pays 80%
Office Visits (except as noted below)	Plan pays 80% after ded.		Plan pays 70% after ded.	Plan pays 60% after ded.	Plan pays 70% after ded.	Plan pays 60% after ded.
Behavioral Health Outpatient Office Visits* (mental health and substance abuse)	Plan pays 80% after ded.		Plan pays 70% after ded.	Plan pays 70% after ded.	Plan pays 70% after ded.	Plan pays 70% after ded.
Hospital Inpatient	Plan pays 80% after ded.		Plan pays 70% after ded.	Plan pays 60% after ded.	Plan pays 70% after ded.	Plan pays 60% after ded.
Emergency Care for Real Emergencies (non-emergencies have different coinsurance levels)	Plan pays 80% after ded.		Plan pays 70% after ded.		Plan pays 70% after ded.	
Diagnostic/X-rays	Plan pays 80% after ded.		Plan pays 70% after ded.	Plan pays 60% after ded.	Plan pays 70% after ded.	Plan pays 60% after ded.
Outpatient Surgery	Plan pays 80% after ded.		Plan pays 70% after ded.	Plan pays 60% after ded.	Plan pays 70% after ded.	Plan pays 60% after ded.

* Benefit features and amounts noted in boldface indicate changes from 2022.

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

Express Scripts Prescription Drug Coverage

All medical plan options offer prescription drug coverage through Express Scripts Inc. (ESI). The amount you pay for prescription drugs will depend on:

- The medical plan option you choose
- Whether you use an in-network retail pharmacy, an out-of-network retail pharmacy, Smart90 or mail order
- The category of drug you use — generic, non-preferred brand or preferred brand

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

There are two options for obtaining maintenance medications (up to a 90-day supply) through either Express Scripts Home Delivery Pharmacy or the Smart90 program. Please review this section carefully for additional details on this important benefit.

The prescription drug in-network benefits shown in the Your 2023 Prescription Drug Benefits at a Glance summary are paid when you use an Express Scripts network pharmacy, the Smart90 or mail order program. Under the Choice Plus HSA and Choice Plus Value HSA prescription drug benefits, retail prescriptions are offered in-network and out-of-network. There are no out-of-network mail order program prescription drug benefits for any prescription benefit plan. In-network benefits are paid up to negotiated rates. Out-of-network benefits are subject to reasonable and customary rates and the member is responsible for any amounts above the reasonable and customary rate.

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

Your 2023 Prescription Drug Benefits at a Glance

When you choose an Evonik Medical Plan, you automatically receive Prescription Drug coverage provided by Express Scripts Inc. (ESI).

	Cyro Pre-65 (BCBS of AL)	Choice Plus HSA (BCBS of AL)	Choice Plus Value HSA (BCBS of AL)
Retail - In-network benefits paid when prescription drugs are filled at a Retail Express Scripts Network Pharmacy Up to 30-day supply (acute medications and first three fills of a maintenance medication)			
Generic	$7 copay	Plan pays 70% after deductible	Plan pays 70% after deductible
Preferred Brand	$50 copay	Plan pays 70% after deductible	Plan pays 70% after deductible
Non-Preferred Brand	$20 copay	Plan pays 70% after deductible (In-network and out-of-network benefits are subject to the applicable deductible and coinsurance.)	Plan pays 70% after deductible (In-network and out-of-network benefits are subject to the applicable deductible and coinsurance.)
Home Delivery Pharmacy or Smart90 – Benefits paid in-network only (Up to a 90-day supply)			
Generic	$14 copay	$0 after deductible	$0 after deductible
Preferred Brand	$40 copay	$40 after deductible	$40 after deductible
Non-Preferred Band	$100 copay	$100 after deductible	$100 after deductible

In-network benefits are paid up to negotiated rates. Out-of-network benefits are subject to reasonable and customary rates and the member is responsible for any amounts above the reasonable and customary rate.

Save Money if You Take a Maintenance Medication

With Express Scripts, you have two cost-saving options for obtaining up to a 90-day supply of maintenance medications, such as for allergies, heart disease, high blood pressure or diabetes. You can choose either Express Scripts Home Delivery Pharmacy or the Smart90 program. Both programs are detailed below. If you do not use one of these programs for your maintenance medications after the third fill, you will pay 100% of the medication cost.

Express Scripts Home Delivery Pharmacy®

- When you use a particular Prescription Drug for an extended period of time (maintenance drug), you can use the Express Scripts Pharmacy® mail-order service. You are able to obtain up to a 90-day supply of Prescription Drugs through the mail order service. When you first begin taking a new medication that is being prescribed for regular long-term use, you may want to initially fill your prescription at a participating pharmacy rather than order a large supply through the Express Scripts Pharmacy® mail-order service. This safeguards you against wasting a 90-day supply that you may be unable to use if your physician changes the medication or the dosage.
- If you take prescription medicine on an ongoing basis, you can order from Express Scripts Home Delivery Pharmacy. Once you start, you can refill and renew your prescriptions from the website or mobile app — and free standard shipping is included. With Express Scripts' mail-order pharmacy, you may obtain up to a 90-day supply of medication for each prescription.

Express Scripts Smart90 Program

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

pharmacy. Each prescription will be subject to your elected medical plan option's retail prescription plan design.

- To continue to fill your maintenance medication at a retail pharmacy, beginning with the fourth fill, you must fill the prescription through a Smart90 CVS or Walgreens participating pharmacy or another Smart90 participating pharmacy if you live in an area where there is not a CVS or Walgreens. You pay your medical plan option's mail order copay, after any deductible, for each fill and in most cases you will save money.
- If you continue to use the Express Scripts retail network pharmacy (other than a Smart90 CVS or Walgreens retail pharmacy) to refill the same maintenance medication after the third fill, you will be responsible for 100% of the prescription drug cost.

Maintenance Medication Example

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

- Your first three fills: Assuming you have already met the deductible, you would pay $12 for each fill (30% of $40), for a total of $36 for a 90-day supply.
- After the third fill: If you choose the Express Scripts Home Delivery or Smart90 program for your fourth fill for a 90-day supply, after you meet the annual deductible, you would pay nothing because there's no copay for generic medications filled through Express Scripts Home Delivery or a Smart90 pharmacy after you meet the deductible. If you continue to use the retail pharmacy (other than a Smart90 CVS or Walgreens retail pharmacy) for refills, you will be responsible for 100% of the medication's cost.

Drug Quantity Management

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

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

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

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

Prior Authorization

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

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

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

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

The Express Scripts formulary includes information about whether a medication requires PA. The formulary is available at www.express-scripts.com.

Step Therapy

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

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

Accredo Specialty Pharmacy

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

Under your prescription drug benefits program, some specialty medications may not be covered at your current pharmacy, or they may only be covered when ordered through Accredo, Express Script's specialty pharmacy.

Accredo is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling.

Services include:

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

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

SaveonSP

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

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

Opioid Management Program

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

Health Savings Accounts (HSAs) Offered Under the Choice Plus HSA Plan and Choice Plus Value HSA Plan

Health Savings Accounts (HSAs) are tax-favored savings accounts available only to individuals enrolled in a high-deductible health plan (HDHP). You can make contributions to your HSA up to the IRS limits and then use the money to pay for eligible health- related expenses. An HSA balance can accumulate quickly, within IRS guidelines, because HSAs have different funding options than other tax-advantaged accounts.

The HSA is a bank account that you own. Money that you contribute to the account can be rolled over from year to year, earn tax-free interest and be invested.

Who is eligible to participate in a Health Savings Account?

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

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

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

How much can be contributed to the Health Savings Account in 2023?

The IRS maximum contribution limit for calendar year 2023 is $3,850 for individual coverage or $7,750 for two-person or family coverage. Individuals from age 55 up to Medicare entitlement can contribute an additional "catch-up contribution." The catch-up contribution limit for 2023 is $1,000. Even if your spouse is over age 65, you can still make HSA contributions up to these limits.

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

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

How do I set up an HSA if I'm contributing for the first time?

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 or 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.

What expenses can be reimbursed with an HSA?

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

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

- Your health plan deductible (the amount you pay before your plan starts paying a share of your costs).
- Your share of the cost for doctor's office visits and prescription drugs.
- Your share of the cost for eligible dental care, including exams, X-rays, cleanings and orthodontia.
- Your share of the cost for eligible vision care, including exams, eyeglasses, contact lenses and laser eye surgery.
- Your tax qualified Long-Term Care premiums (the amount considered a qualified medical expense depends on your age).
- Your health insurance premiums if you are collecting federal or state unemployment benefits, or if you have COBRA continuation coverage through a former employer.
- You may not be reimbursed for any expense that is reimbursed by another source.

Can I make contributions to the HSA after age 65?

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

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

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

While I was an active employee, Evonik contributed to my HSA. Will Evonik contribute to my HSA now that I am participating as a retiree?

No. Evonik does not contribute to the HSA of retirees. However, you may continue making contributions until your enroll in Medicare (you will need to open an HSA account outside of Evonik). You may use available HSA funds from your Optum HSA account to pay for qualified health expenses, or you may transfer your Optum HSA account to your newly opened HSA.

Can I access my HSA funds after age 65?

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

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

- Qualified health expenses
- Medicare Part B premiums
- Medicare Part D (prescription drug plan) premiums and copays
- Medicare Advantage HMO (Part C) (cannot be used for Medicare Supplement Plan or Medigap plan premiums)
- Retiree premiums for employer-sponsored health insurance
- Pre-65 spouse's premiums if enrolled in a group plan

Once you turn age 65, you can also use your account to pay for things other than qualified health expenses. If used for non-health expenses, the amount withdrawn

will be taxable as income but will not be subject to any other penalties.

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

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

Qualified health expenses are determined by the IRS and include medical, prescription drug, dental, vision and certain premium expenses. Again, you are responsible for making sure your expenses are eligible according to IRS publication 502, available at www.irs.gov/pub/irs-pdf/p502.pdf. Additionally, keep your receipts in case you need to defend your expenditures or decisions during an audit.

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

How do I withdraw money from my HSA Bank Account?

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

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

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

What are the survivor benefits associated with my HSA?

Based on current IRS regulations, if you name your spouse, the account remains an HSA, and your spouse will become the owner. When the beneficiary is not your spouse, the HSA ends on the date of your death. Your heir receives a distribution and the fair-market value becomes taxable income to the beneficiary — though the taxable amount can be reduced by any qualified health expenses incurred by the deceased that are then paid by the beneficiary within a year of the death. Failure to name a beneficiary at all means the assets in your account will be distributed to your estate and included on your final income tax return.

How do I report HSA activity on my tax return?

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

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

Changing Your Elections During 2023

The benefit choices you make must generally remain in effect for the full calendar year, so it is important to consider your options carefully. IRS rules permit you to make certain changes to Company-sponsored benefits elections only after a "qualified status change."

If you or your dependents have a qualified status change, you have 31 days from the event to change your benefits on the Retiree Benefits website.

If you do not make election changes within this 31-day period, you cannot make changes to your benefits until the next Annual Enrollment period.

Qualified status changes include significant life events such as:

- Change in legal marital status, such as divorce, legal separation, death of your spouse, or annulment
- Birth or adoption of a child
- Residence change
- Loss of coverage
- Significant restriction or reduction in coverage
- Availability of new benefit option or significant improvement to a current benefit option
- Significant changes in cost
- Qualified Medical Child Support Order (QMCSO)
- Death of a child
- Dependent's loss of eligibility

Please note: If you have a qualified status change between now and the end of the 2022 Plan Year, you will need to update your enrollment for both 2022 and 2023. In addition, if you are adding a dependent as a result of a life event, the dependent will need to be verified for eligibility. See "Be Sure Your Dependents Are Eligible for Coverage" on page 2 for eligibility rules.

Contact Information

VENDOR	TELEPHONE NUMBER	WEBSITE
Mercer Retiree Service Center	+1 855-684-6628	www.evonikretireebenefits.com
Billing and Payments	+1 855-684-6628	You can log onto either www.evonikretireebenefits.com or www.mercermyaccount.com
BCBS of AL Medical Plans Cyro Pre-65 Plan(Group # 91606 Plan A 91608 Plan B, C, D) Choice Plus HSA (Group # 91305) Choice Plus Value HSA (Group # 91306)	+1 833-994-0014	www.AlabamaBlue.com Use contract prefix “DHC”, or under “Select All Plans,” choose “BlueCard PPO Network”
Empower (formerly Prudential) 401(k)/Pension	+1 877-778-2100	www.prudential.com/online/retirement
Express Scripts (Group # EVONIK1)	+1 877-657-2496	www.express-scripts.com/evonik
Health Advocate	+1 866-695-8622	

Notices and Disclosures

Affordable Care Act Requirements

Under the Affordable Care Act (ACA), Evonik is required to provide IRS Form 1095 by January 31, 2023, to all employees and/or dependents who were covered under an Evonik medical plan in 2022.

Evonik Corporation Health Plans Notice of Privacy Practices

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

General Information About This Notice

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

The Health Plans

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

- Retiree Medical Plan, Retiree Dental Plan, and Retiree Vision Plan Benefits, as applicable, under the Evonik Corporation Consolidated Retiree Welfare Benefits Program

These health plans provide health benefits to eligible retirees and their eligible dependents.

What Information Is Protected?

The HIPAA privacy rules require the Health Plans to establish policies and procedures for safeguarding a category of medical information called "protected health information," or "PHI," received or created in the course of administering the Health Plans. PHI is health information that can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or payment for your health care. A claim form for medical or dental benefits and the explanation of benefits statements (EOBs) sent in connection with payment of your claims are examples of documents containing PHI.

This Notice only applies to health-related information received by or on behalf of the Evonik Health Plans. If Evonik obtains your health information in another way — for example, if you are hurt in a work accident or if you provide medical records with your request for leave under the Family and Medical Leave Act — then this Notice does not apply, but Evonik will safeguard that information in accordance with other applicable laws and Evonik policies. Similarly, health information obtained in connection with a non-Health Plan benefit, such as long-term disability or life insurance, is not protected under this Notice. This Notice also does not apply to information that does not identify you and with respect to which there is no reasonable basis to believe that the information can be used to identify you.

Uses and Disclosures That Do Not Require Your Authorization

The Health Plans may use or disclose your PHI in certain permissible ways, provided that the legal requirements applicable to the use or disclosure are followed, described below. Not every use or disclosure in a category will be listed. However, all of the ways the Health Plan is permitted to use and disclose information will fall within one of the categories. Most of the time, the PHI used and disclosed by the Health Plans will be limited to the minimum amount of PHI necessary for these purposes.

- Treatment. The Health Plan may use or disclose protected health information to facilitate medical treatment or services by health providers. The Health Plan may disclose health information about you to health care providers, including doctors, nurses, technicians, or hospital personnel who need the information to take care of you. For example, the Health Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription conflicts with your current prescriptions.
- Payment. The Health Plan may use or disclose protected health information to make payments to health care providers who are taking care of you. The Health Plan may also use and disclose protected health information to determine your eligibility for Health Plan benefits, to evaluate the Health Plan's benefit responsibility, and to coordinate Health Plan coverage with other coverage you may have. For example, the Health Plan may share information with health care providers to determine whether the Health Plan will cover a particular treatment. The Health Plan may also share your protected health information with another organization to assist with financial recoveries from responsible third parties.

- Health Care Operations. The Health Plans may use and disclose your PHI for their health care operations — for example, to arrange for medical review, for disease management, to conduct quality assessment and improvement activities, or for underwriting. However, the Health Plans are prohibited from using or disclosing your genetic information for underwriting purposes. The Health Plans also may disclose your PHI to another health plan or a health care provider that has or had a relationship with you for it to conduct quality assessment and improvement activities; for accreditation, certification, licensing, or credentialing activities; or for the purpose of health care fraud and abuse detection or compliance — for example, for the other health plan to perform case management or health care provider performance evaluations, or for the health care provider to evaluate the outcomes of treatments or conduct training programs to improve health care skills.
- To Comply With Law. The Health Plans may use and disclose your PHI to the extent required to comply with applicable law.
- Disclosures to Evonik Health Plan. The Health Plans may disclose your PHI to certain employees or other individuals under Evonik's control to allow Evonik to administer the Health Plans, as described in this Notice. In addition, Evonik may use or disclose "summary health information" for purposes of obtaining premium bids or modifying, amending, or terminating the Health Plans. Summary health information is information that summarizes claims history, claims expenses, or types of claims experienced by individuals for whom Evonik provides benefits under the Health Plans and from which the individual's identifying information, except for five-digit ZIP codes, has been deleted. Evonik cannot use your PHI obtained from the Health Plans for any employment-related actions without your written authorization.

  Evonik uses and discloses Health Plan enrollment/disenrollment information for payroll-related activities. However, this enrollment/disenrollment information is held by Evonik in its role as the employer and is not subject to the HIPAA privacy rules or this Notice.
- Third Party Providers (Business Associates). The Health Plans contract with third party administrators and various service providers, called "business associates," to perform certain plan administration functions. The Health Plans' business associates will receive, create, maintain, transmit, use, and disclose your PHI, but only after the business associates have agreed in writing to appropriately safeguard and keep confidential your PHI. Aetna, UnitedHealthcare, and Blue Cross Blue Shield of Alabama (medical claims administrators) are examples of Health Plan business associates. Business associates may also use or disclose your PHI on behalf of the Health Plans, as described in this Notice.
- Disclosures to Family Members and Friends. The Health Plans may disclose your PHI to your family members, close friends, or other persons involved in your health care if you are present and you do not object to the disclosure (or if it can be inferred that you do not object), or, if you are not present or are unable to object due to incapacity or emergency, the disclosure is in your best interest. Following your death, the Health Plans may disclose your PHI to your family members, close friends, or other persons who were involved in your health care unless doing so would be against your stated preferences. Disclosure will be limited to your PHI that is directly relevant to the person's involvement in your health care.
- Lawsuits and Disputes. The Health Plans may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order, subpoena, discovery request, or other lawful process.
- Workers' Compensation. The Health Plans may disclose your PHI as necessary to comply with workers' compensation or similar laws or programs.
- Law Enforcement. The Health Plan may disclose protected health information if asked to do so by a law-enforcement official in certain limited circumstances.
- Public Health. The Health Plans may use or disclose your PHI for certain public health activities, including to a public health authority for the prevention or control of disease, injury, or disability; to a proper government or health authority to report child abuse or neglect; to report reactions to medications or problems with products regulated by the Food and Drug Administration; to notify individuals of recalls of medication or products they may be using; to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition; or to provide immunization information to a school about a student or potential student.
- Health Oversight. The Health Plan may disclose protected health information to a health oversight agency for activities authorized by law, including, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- Research. In very limited situations, the Health Plan may disclose protected health information to researchers; however, usually we will need to get your authorization.
- Compliance with HIPAA. The Health Plan is required to disclose protected health information to the United States Department of Health and Human Services when requested to determine compliance with HIPAA.
- Coroners, Medical Examiners, and Funeral Directors. The Health Plan may disclose protected health information to a

coroner, medical examiner, or funeral director, as necessary for them to carry out their duties.

- National Security and Intelligence Activities. The Health Plan may disclose protected health information to authorized federal officials for national security activities authorized by law.
- Military. The Health Plan may disclose protected health information as required by military and veterans authorities if you are or were a member of the uniformed services.

Uses and Disclosures With Your Written Authorization

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

Your Individual Rights

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

- Right to Request Additional Restrictions. You may request restrictions on a Health Plan's use and disclosure of your PHI. While the Health Plans will consider all requests for additional restrictions carefully, the Health Plans are not required to agree to a requested restriction. If you wish to request restrictions on a Health Plan's use and disclosure of your PHI, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is used or disclosed by third party vendors (business associates) that administer the Health Plans (for example, most medical PHI is maintained by the medical claims administrators). To request restrictions on the use or disclosure of your PHI by these vendors, you may wish to contact the vendors directly. For more information on your right to request restrictions, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).
- Right to Receive Confidential Communications. You may request to receive your PHI by alternative means of communication or at alternative locations. Your request must specify how or where you wish to be contacted. The Health Plans will try to accommodate any reasonable request for confidential communication. Please note that in certain situations, such as with respect to eligibility and enrollment information, the Health Plans are obliged to communicate directly with the retiree rather than a dependent unless your request clearly states that disclosure of that information through the normal methods could endanger you. If you wish to request confidential communication of your PHI, you may obtain a request form from the Privacy Officer. Most communications of PHI relating to your health benefits are made by third party vendors (business associates) that administer the Health Plans. To request confidential communication of your PHI by these vendors, you may wish to contact the vendors directly. For more information on your right to request confidential communication of your PHI, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).
- Right to Inspect and Copy Your PHI. You may request access to certain Health Plan records that contain your PHI in order to inspect and request copies of those records. If you request copies, the Health Plans may charge you copying, mailing, and labor costs. To the extent that your PHI is maintained electronically, you may request that the Health Plans provide a copy to you or to a person or entity designated by you in an electronic format. Under limited circumstances, a Health Plan may deny you access to a portion of your records. If you desire access to your records, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is created or maintained by third party vendors (business associates) that administer the Health Plans. For access to that information, you may wish to contact the vendors directly. For more information on your right to inspect and request copies of your PHI, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).
- Right to Amend Your Records. You have the right to request that the Health Plans amend your PHI maintained in the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Health Plans and any other records used by or for the Health Plans to make decisions about your benefits. The Health Plans will comply with your request for amendment unless special circumstances apply. A Health Plan may deny your request for amendment if you do not provide a reason to support your request or if the Health Plan believes that the information is accurate. In addition, a Health Plan may deny your request if you ask it to amend information that was created by another health plan or health care provider (but the Health Plan will inform you of the source of the information, if known). If your physician or other health care provider created the information that you desire to amend, you should contact the health care provider to amend the information. To make a request for amendment, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits

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

- Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made by the Health Plans made within six years of the date of your request. The accounting will generally be provided free of charge, but if you request an accounting more than once during a twelve (12) month period, the Health Plans may charge you a reasonable fee for any subsequent accounting statements. You will be notified of the costs involved, and you may choose to withdraw or modify your request before you incur any expenses. The accounting will not include all disclosures of your PHI. For example, the accounting will not include disclosures (i) to carry out treatment, payment or health care operations activities; (ii) made to you; (iii) made to friends or family members involved in your care; (iv) made pursuant to your written authorization; (v) for national security or intelligence purposes; or (vi) to correctional institutions or law enforcement officials. If you wish to request an accounting, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is used or disclosed by third party vendors (business associates) that administer the Health Plans. For an accounting of disclosures by a Health Plan vendor, you may wish to contact the vendor directly. For more information on your right to request an accounting, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).
- Right to Receive Paper Copy of This Notice. You may obtain a paper copy of this Notice upon request to the Privacy Officer.
- Right to Notification of a Breach of Your PHI. You will be notified in the event of an improper use or disclosure of your PHI if a Health Plan determines that the privacy of your PHI was likely compromised.
- Personal Representatives. You may exercise your rights through your personal representative who has authority under applicable state law to make health-related decisions on your behalf. Your personal representative will be required by the Health Plans to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or evidence that you are the parent of a minor child. The Health Plans reserve the right to withhold your PHI from your personal representative in certain limited circumstances.

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

Effective Date and Application of This Notice. This Notice Is Effective as of August 2022.

Health Plan's Responsibilities

HIPAA requires the Health Plan To:

- Maintain the privacy of protected health information;
- Provide you with a copy of this Notice;
- Follow the terms of the Notice that is currently in effect; and
- Notify affected individuals following a breach of unsecured protected health information.

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

If You Participate in an Insured Coverage Option. This Notice generally applies to Evonik and to the self-insured health benefit programs under the Health Plans. If you participate in an insured HMO, DMO, or other insured coverage option through the Health Plans, this Notice also describes Evonik's use and disclosure of your health information. However, your HMO, DMO, or health insurance provider should provide you with a separate notice of privacy practices that describes the HMO/DMO provider's or insurer's own privacy policies and procedures. Contact your HMO/ DMO provider or insurance company for a copy of the most current notice.

Complaints. If you believe that your privacy rights have been violated, you may file a complaint with the Health Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Health Plan, contact the Privacy Officer in writing. You will not be

penalized, or in any other way retaliated against, for filing a complaint.

Privacy Officer

You may contact the Privacy Officer at:

Law Department
Evonik Corporation
299 Jefferson Road
Parsippany, NJ 07054

ATTENTION: HIPAA Privacy Officer

Telephone Number: +1 800-334-8772
Email: compliance.program@evonik.com

Keep Your Health Plans Informed of Address Changes

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

Women's Health and Cancer Rights Act of 1998

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

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

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

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan. The annual deductibles and coinsurance are listed in your benefit plan documents. If you would like more information on WHCRA benefits, contact the Mercer Marketplace 365+ Benefits Center at +1 855-684-6628.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care — like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

For emergency services, New Jersey law provides the same protections as federal law.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

New Jersey law provides similar protections as federal law.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you think you have been wrongly billed, you may contact the following agencies to file a complaint:

New Jersey Department of Banking and Insurance at the Office of Managed Care 1-888-393-1062 or www.state.nj.us/dobi/division_insurance/managedcare. Visit www.state.nj.us/dobi/division_consumers/insurance/outofnetwork.html for more information about your rights under New Jersey law.

The federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Affiliates of Evonik Corporation (as of January 1, 2023)

AFFILIATE NAME	ADDRESS	PHONE NUMBER	EIN
Evonik Corporation	299 Jefferson Road, Parsippany, NJ 07054	+1 973-929-8000	62-0673043
Silbond Corporation	9901 Sandy Creek Highway, Weston, MI 49289	+1 517-436-3171	38-3142234
Degussa International, Inc.	220 Continental Drive, Newark, DE 19713	+1 302-731-9250	52-2055522
Evonik Oil Additives USA, Inc.	723 Electronic Drive, Horsham, PA 19044	+1 215-706-5800	23-2968683
Wilshire Technologies Inc.	243 Wall Street, Princeton, NJ 08540	+1 609-683-1117	22-3547692
Evonik Active Oxygens LLC	One Commerce Square, 2005 Market Street, Suite 3200, Philadelphia, PA 19103	+1 866-860-4760	30-0805773
Porocel Industries, LLC	10300 Arch St., Pike Little Rock, AR 72206	+1 501-888-1357	20-3871387
Evonik Superabsorber LLC	2401 Doyle Street, Greensboro, NC 27406	+1 336-333-7540	86-1942825
Catalyst Recovery of Louisiana, LLC	100 American Blvd, Lafayette, LA 70508	+1 337-837-1191	20-1885434

Disclaimer

This overview highlights certain features and rules for Cyro Retirees of Evonik Cyro LLC (the Company) participating in the Evonik Corporation Retiree Medical Plan. This overview is not intended to be a substitute for the official plan documents or summary plan descriptions. More detailed information about your benefits can be found in the applicable summary plan descriptions, available on the retiree benefit website.

Benefits provided by Evonik and the details of those benefit plans are subject to change. Eligibility and other requirements may need to be satisfied to receive certain benefits.

In the event there is a conflict between the terms of the official plan documents and the information contained in this brochure or in presentations, or discussed in meetings, the terms of the plan documents will govern all rights and obligations of plan participants, beneficiaries, and fiduciaries and of Evonik Corporation.

Evonik reserves the right, at its sole discretion, to modify, suspend, change or terminate the plans, the benefits provided under the plans, and the costs of plan coverage at any time, subject to any outstanding collective bargaining or other contractual agreements and as permitted by law.

This brochure constitutes a Summary of Material Modifications as required by ERISA and should be kept with your Summary Plan Description for the Plan.

October 2022