2025 Annual Enrollment Information for Evonik Medicare Eligible Retirees

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EVONIK
Leading Beyond Chemistry

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October 2024

Welcome to 2025 Annual Enrollment

The Annual Enrollment period for 2025 Evonik Age 65 & older retiree benefits begins on October 21, 2024 and ends on November 4, 2024. **You do not need to do anything to continue your current coverage for yourself and your Age 65 & Over Medicare eligible dependents.** If you wish to **decline or change** your or your dependent(s)' 2025 coverage, please refer to the **How to Enroll** section of this document.

Retiree Benefits Administration Provided by Aptia

Earlier this year Mercer sold its benefits administration business to Aptia. Aptia is now the administrator for Evonik's retiree benefits. Aptia provides a comprehensive customer service experience for our retirees.

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

What's New for 2025

- Effective January 1, 2025, medical premiums and contributions for the BCBS Traditional Choice plan will be increasing 18.3%. Like many companies, the combined effect of inflation and general health care cost increases have made it necessary to make this decision. Please see your enrollment form which details your new contributions.
- The BCBS Traditional Choice benefit plan design will remain unchanged, with no increases to coinsurance, deductibles and out-of-pocket costs.

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 2025, 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. Aptia 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.

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 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 Evonik Retiree Service Center, +1 855-684-6628, Monday through Friday, from 8:00 am to 9:00 pm ET.

Benefit Resources

Benefits Website

You have 24/7 access to Aptia's Retiree Benefits website, **www.** Retiree **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)
- Annual Summary Plan Descriptions (SPD)
- Sign-up for electronic funds transfer to pay your retiree contributions

Retiree Service Center

When you call the Evonik Retiree Service Center 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 Enroll

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

The good news is…you are already enrolled! We will continue to offer the BCBS Traditional Choice Plan design that you are currently enrolled in. If you don't want to make changes to your current benefit elections, you do not need to do anything or submit any paperwork.

If you wish to decline or change your or your dependent(s) coverage, please follow the instructions below:

- **Mail:** Complete the enclosed enrollment form and return it to Aptia in the envelope provided. Note, enrollment forms must be postmarked by Friday, November 4; or
- **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 make a change through the Retiree Service Center, you must complete your enrollment by **Monday, November 4**.

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 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, conditions, treatments, and tests
- Review treatment options grounded in evidence-based practices
- Help you prepare for doctor visits, review results, and plan future actions
- Discuss the cost and quality of services to help make informed decisions
- Coordinate care and clinical services with treating physicians
- Provide medical decision support, such as by helping you arrange second opinions
- Schedule appointments and arrange the transfer of medical records
- Research ways to reduce prescription and healthcare costs
- Facilitate pre-authorization
- Locate doctors and specialists

Administrative Support

- Resolve healthcare, claims and medical bill issues
- Review and negotiate medical bills
- Provide support for any insurance-related questions or issues
- Clarify coverage and benefits
- Assist with special help for parents, parents-in-law, retirees and pre-Medicare retirees, such as to locate community and eldercare resources
- Explain all parts of Medicare and Medicaid
- Help with appeals

Health Advocate can be reached at +1 866-695-8622, or by visiting **www.HealthAdvocate.com/Evonik**. 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 2025 Medical Plan

For 2025, we will continue to offer the Blue Cross Blue Shield (BCBS) Traditional Choice plan, administered by Blue Cross Blue Shield of Alabama. Please note that the BCBS Traditional Choice medical plan deductibles, out-of-pocket maximums and coinsurance remain unchanged for 2025.

Medical Plan Highlights

This chart below shows general coverage information for the BCBS Traditional Choice plan.

BCBS Traditional Choice	
Annual Deductible	Retiree Only: $600 Retiree +1: $1,200 Retiree + Family: $1,800
Out-of-Pocket Maximum (includes deductible)	Retiree Only: $2,400 Retiree +1: $4,800 Retiree + Family: $7,200
Preventive Care	Plan pays 80% (deductible waived)
Office Visits	Plan pays 80%, after deductible
Hospital Inpatient	Plan pays 80%, after deductible
Emergency Care	Plan pays 80%, after deductible
Diagnostic/X-rays	Plan pays 80%, after deductible
Outpatient Surgery	Plan pays 80%, after deductible

Coordination of Benefits (COB) with Medicare

The BCBS Traditional Choice Plan is not a Medicare supplemental plan. You are responsible for your deductible and coinsurance up to the annual out-of-pocket maximum under the BCBS Traditional Choice Plan.

If you are eligible for primary coverage under Medicare – regardless of whether you are enrolled for Medicare – the Evonik Medical Plan will reduce its benefits by the amount Medicare paid or would have paid as the primary payer for the same expense. For an individual with primary coverage through Medicare, the allowable amount for covered expenses is the Medicare allowable amount.

The following example shows how COB works when Medicare is the primary payer. This example assumes that both the Medicare Part B deductible and the BCBS Traditional Choice plan deductible have been satisfied. For an outpatient surgery charge:

Primary Plan	Medicare
Secondary Plan	Evonik BCBS Traditional Choice Medical Plan
Charge (for an outpatient surgeon's service)	$100 (Medicare Allowable Amount)
Medicare Benefit	$80 (80% x $100 = $80) Medicare pays 80% of the Medicare Allowable Amount after the Part B Deductible.
Evonik BCBS Traditional Choice Medical Plan if It Were the Primary Plan	$80 (80% of the Allowable Amount of $100)
BCBS Traditional Choice Medical Plan after Coordination of Benefits	$0 The amount the Evonik BCBS Traditional Choice Medical Plan would have paid, as the primary payer is reduced by the amount Medicare paid. The Evonik BCBS Traditional Choice Medical Plan would pay $0 because Medicare paid what the BCBS Traditional Choice Plan would have paid.

Express Scripts Prescription Drug Coverage

Express Scripts Inc. (ESI) will continue to administer the prescription drug benefit in 2025. The amount you pay for prescription drugs will depend on:

- 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.

Here is a summary of in-network prescription drug benefits when you use an Express Scripts network pharmacy or the Smart90/mail order program. Note: There are no changes to the retail and mail order prescription drug copays. Please refer to the Smart90 program regarding maintenance medications and applicable copays.

Your 2025 Prescription Drug Benefits at a Glance

Note: Plan shows in-network prescription drug benefit levels only.

Prescription Drug Plan – Medicare Eligible

BCBS Traditional Choice	
Annual Prescription Maximum Per Person	$2,500
Retail **Up to 30-day supply (acute medications and first three fills of a maintenance medication)**	
Generic	$10 copay
Preferred Brand	$25 copay
Non-Preferred Brand	$45 copay
Home Delivery Pharmacy or Smart90	
Generic	$20 copay
Preferred Brand	$50 copay
Non-Preferred Brand	$90 copay

The Prescription Drug program under the BCBS Traditional Choice plan has a $2,500 annual maximum per individual for Covered Persons once you become eligible for Medicare. The maximum is based on the Plan's cost for the drugs. **With a $2,500 maximum payable amount, the Evonik prescription drug program under the BCBS Traditional Choice plan does not pay out as much as the standard Medicare Part D prescription drug coverage; therefore, the coverage is deemed non-creditable.** Because the Evonik Medicare prescription drug plan is non-creditable, you should enroll in a Medicare prescription drug plan. You can enroll in a Medicare prescription drug plan when you or your covered dependent first become eligible for Medicare and each year from November 15 through December 31.

If you do not enroll when first eligible, you may be required to pay a higher premium (a penalty) if you join later, and you will pay that higher premium as long as you have Medicare prescription drug coverage.

Detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook from Medicare. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at **1-800-772-1213 (TTY 1- 800-325-0778)**.

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 BCBS Traditional Choice plan. The cost of a 30-day supply of the medication is $10. 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 $10 for each fill for a total of $30 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 $20 for generic medications filled through Express Scripts Home Delivery or a Smart90 pharmacy. 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.

Contact Information

VENDOR	TELEPHONE NUMBER	WEBSITE
Evonik 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 Traditional Choice Plan (Group # 90620)	**+1 833-994-0014**	**www.AlabamaBlue.com**
Empower 401(k)/Pension	**+1 888-826-4015**	**www.empowermyretirement.com**
Express Scripts (Group # EVONIK1)	**+1 877-657-2496**	**www.express-scripts.com/evonik**
Health Advocate	**+1 866-695-8622**	**https://www.healthadvocate.com/evonik**

Notices and Disclosures

To the extent applicable, the Evonik Corporation Consolidated Welfare Benefits Program (Plan) will provide coverage and benefits in accordance with the requirements of all applicable laws, including, but not limited to, the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), Newborns' and Mothers' Health Protection Act of 1996, as amended (NMHPA), Women's Health and Cancer Rights Act of 1998 (WHCRA), Family and Medical Leave Act of 1993 (FMLA), Mental Health Parity Act (MHPA), Mental Health Parity and Addiction Equity Act (MHPAEA), Health Information Technology for Economic and Clinical Health Act (HITECH), Michelle's Law, Genetic Information Nondiscrimination Act of 2008 (GINA), the Patient Protection and Affordable Care Act (PPACA), and the Consolidated Appropriations Act of 2021 (the "CAA").

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"):

- Medical Plan, Dental Plan, Living Well Resources, and Vision Plan benefits under the Evonik Corporation Consolidated Welfare Benefits Program
- Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account Benefits provided under the Evonik Corporation Flexible Spending Account Plan
- Retiree Medical Plan, Retiree Dental Plan, and Retiree Vision Plan Benefits under the Evonik Corporation Consolidated Retiree Welfare Benefits Program

These Health Plans provide health benefits to eligible Evonik employees and 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.

If the Evonik discloses your health information in a permissible manner, this Notice does not apply to the redisclosure of that PHI by the recipient.

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. However, the Health Plans are prohibited from using or disclosing your substance use disorder treatment records received from federally assisted programs, or testimony describing the content of those records, in civil, criminal, administrative, or legislative proceedings against you unless based on your written consent or a court order accompanied by a subpoena.
- **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.

Prohibited Uses and Disclosures Related to Reproductive Health Care

Notwithstanding the above, the Health Plans are prohibited from using or disclosing your PHI related to reproductive health care that is lawfully obtained under the circumstances in which it was provided to conduct a criminal, civil, or administrative investigation; impose criminal, civil, or administrative liability; or identify any person for the purpose of conducting such investigation or imposing such liability. This prohibition applies as long as the reproductive health care is lawful in the state where it was provided, is protected by federal law, and was not provided by the covered entity receiving the request for disclosure.

- **Disclosures Required by Law.** The permission of the Health Plans to disclose your PHI as "required by law" is limited to laws that expressly require such reporting and must be limited to only the relevant information. For example, if you travel to another state to receive reproductive health care, unless that state has a law that requires the affirmative reporting of such treatment, then there is no obligation to report your PHI to authorities.
- **Disclosures for Law Enforcement Purposes.** The Health Plans may use and disclose your PHI to the extent required to comply with a court-ordered warrant, subpoena, or summons. For example, a direct request by a law enforcement official for abortion records, would not be permissible.
- **Disclosures to Avert a Threat to Health or Safety.** An individual's intent to get an abortion in another state where it is legal, or any other reproductive health care, is not a serious threat to health or safety of a person or the public. The Health Plans are prohibited from using or disclosing your PHI about such treatment for certain public health activities.

Any individual who requests your PHI that is potentially related to reproductive health care will be required to complete an attestation acknowledging that the PHI will not be used for any of the prohibited purposes described in this section.

Your Individual Rights

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

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

wish to contact the vendors directly. For more information on your right to request restrictions, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).

- **Right to Receive Confidential Communications.** You may request to receive your PHI by alternative means of communication or at alternative locations. Your request must specify how or where you wish to be contacted. The Health Plans will try to accommodate any reasonable request for confidential communication. Please note that in certain situations, such as with respect to eligibility and enrollment information, the Health Plans are obliged to communicate directly with the employee/retiree rather than a dependent unless your request clearly states that disclosure of that information through the normal methods could endanger you. If you wish to request confidential communication of your PHI, you may obtain a request form from the Privacy Officer. Most communications of PHI relating to your health benefits are made by third party vendors (business associates) that administer the Health Plans. To request confidential communication of your PHI by these vendors, you may wish to contact the vendors directly. For more information on your right to request confidential communication of your PHI, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).
- **Right to Inspect and Copy Your PHI.** You may request access to certain Health Plan records that contain your PHI in order to inspect and request copies of those records. If you request copies, the Health Plans may charge you copying, mailing, and labor costs. To the extent that your PHI is maintained electronically, you may request that the Health Plans provide a copy to you or to a person or entity designated by you in an electronic format. Under limited circumstances, a Health Plan may deny you access to a portion of your records. If you desire access to your records, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is created or maintained by third party vendors (business associates) that administer the Health Plans. For access to that information, you may wish to contact the vendors directly. For more information on your right to inspect and request copies of your PHI, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).
- **Right to Amend Your Records.** You have the right to request that the Health Plans amend your PHI maintained in the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Health Plans and any other records used by or for the Health Plans to make decisions about your benefits. The Health Plans will comply with your request for amendment unless special circumstances apply. A Health Plan may deny your request for amendment if you do not provide a reason to support your request or if the Health Plan believes that the information is accurate. In addition, a Health Plan may deny your request if you ask it to amend information that was created by another health plan or health care provider (but the Health Plan will inform you of the source of the information, if known). If your physician or other health care provider created the information that you desire to amend, you should contact the health care provider to amend the information. To make a request for amendment, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is created or maintained by third party vendors (business associates) that administer the Health Plans. To request amendment of that information, you may wish to contact the vendors directly. For more information on your right to request amendment of your PHI, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).
- **Right to Receive an Accounting of Disclosures.** Upon request, you may obtain an accounting of certain disclosures of your PHI made by the Health Plans made within six years of the date of your request. The accounting will generally be provided free of charge, but if you request an accounting more than once during a twelve (12) month period, the Health Plans may charge you a reasonable fee for any subsequent accounting statements. You will be notified of the costs involved, and you may choose to withdraw or modify your request before you incur any expenses. The accounting will not include all disclosures of your PHI. For example, the accounting will not include disclosures (i) to carry out treatment, payment or health care operations activities; (ii) made to you; (iii) made to friends or family members involved in your care; (iv) made pursuant to your written authorization; (v) for national security or intelligence purposes; or (vi) to correctional institutions or law enforcement officials. If you wish to request an accounting, you may obtain a request form from the Privacy Officer. Most PHI relating to your health benefits is used or disclosed by third party vendors (business associates) that administer the Health Plans. For an accounting of disclosures by a Health Plan vendor, you may wish to contact the vendor directly. For more information on your right to request an accounting, or for contact information for the Health Plan vendors, call or write to the Privacy Officer (contact information below).
- **Right to Receive Paper Copy of This Notice.** You may obtain a paper copy of this Notice upon request to the Privacy Officer.
- **Right to Notification of a Breach of Your PHI.** You will be notified in the event of an improper use or disclosure of your PHI if a Health Plan determines that the privacy of your PHI was likely compromised.
- **Personal Representatives.** You may exercise your rights through your personal representative who has authority under applicable state law to make health-related decisions on your

behalf. Your personal representative will be required by the Health Plans to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or evidence that you are the parent of a minor child. The Health Plans reserve the right to withhold your PHI from your personal representative in certain limited circumstances.

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

Effective Date and Application of This Notice. This Notice Is Effective as of July 2024.

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 Aptia365 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
2 Turner Place
Piscataway, NJ 08854

ATTENTION: HIPAA Privacy Officer

Telephone Number: **+1 732-981-5300**
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.

Rights Pursuant to Genetic Information Nondiscrimination Act of 2008 (GINA)

Evonik Corporation complies with GINA and, therefore, does not:

- Increase group premium or contribution amounts based on genetic information;
- Request or require an individual or family members to undergo genetic testing; or
- Request, require or purchase genetic information prior to or in connection with enrollment or at any time for underwriting purposes.

"Genetic information" is information about (1) an individual's genetic tests; (2) the genetic tests of an individual's family members; (3) the manifestation of a disease or disorder in an individual's family members; or (4) any request or receipt by the individual of his or her family members of genetic information. Genetic information does not include blood tests that are not designed to obtain information relating to genotypes, mutations or chromosomal changes; cholesterol tests; or information about the age or sex of an individual or family member.

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the plan administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of one or more of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of one or more of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of one or more of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Evonik Corporation, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. The employer must notify the plan administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for

coverage as a dependent child), you must terminate his/her coverage with Evonik on Aptia365 within 31 days of when the qualifying event occurs. The COBRA administrator will mail a COBRA package to your home address.

How is COBRA continuation coverage provided?

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the COBRA Administrator is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit:
https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or

visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the COBRA Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

Plan Contact Information

If you have questions regarding COBRA eligibility, please call an Aptia365 Benefits Counselor at **+1 855-684-6628**, Monday through Friday, from 7:00 am to 9:00 pm, ET.

If you have elected COBRA coverage and have questions on your COBRA coverage and/or rates, please contact the COBRA Administrator at:

Inspira Financial
P.O. Box 953374
St. Louis, MO 63195-33741
+1 888-678-7835

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 Aptia365 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 balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance, and/or deductible.

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 additional 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 allowed 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

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, coinsurance, and deductibles). 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 any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network 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.

Disclaimer

This overview highlights certain features and rules of the Evonik benefit plans. 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 Benefits Website - EvonikRetireeBenefits.com.

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 2024