Genesis Alkali, LLC

DENTAL PLAN

SUMMARY PLAN DESCRIPTION

EFFECTIVE September 1, 2017

For:

Green River Hourly Employees

September 2018

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This SPD includes a list of definitions of commonly used terms and phrases, which are *italicized* where they appear in the document.

Introduction

This Summary Plan Description (SPD) describes the Genesis Alkali Dental Plan (Plan). The Plan pays benefits for a wide range of services including preventive care, basic services, major services and orthodontia for your children.

Benefits described in this SPD are as of September 1, 2017. This SPD replaces and supersedes any previous SPDs. However, this SPD is not the document that governs the Plan. The Genesis Alkali Welfare Benefits Program Plan Document (Plan Document) governs this Plan. If there is a conflict between the Plan Document and this SPD, the Plan Document will govern.

This Plan is maintained according to the collective bargaining agreement between Genesis Alkali, LLC (Successor in interest to Tronox Alkali) and the United Steelworkers Local 13214 dated July 1, 2016. A copy of the collective bargaining agreement may be obtained from the Green River Human Resources Department.

Genesis Alkali intends to continue the Plan indefinitely. However, Genesis Alkali reserves the right to terminate or modify the Plan, including employee eligibility to participate, at any time, subject to any applicable collective bargaining obligations. In addition, Genesis Alkali reserves the right to change the cost of coverage unless specific rates have been negotiated by the terms of a collective bargaining agreement. Your participation in the Plan is not a guarantee of continued employment nor does it provide you with any benefits other than those described in this SPD.

Plan Highlights

HIGHLIGHTS

- You have the choice of two dental options:
  - Both options cover the same services.
  - The options differ by deductibles, coinsurance, annual maximum benefit and payroll deductions.
- You may opt-out of dental coverage and receive flex credit in your pay as taxable income.
- You can take advantage of a preferred network of dentists and save on out-of-pocket costs or use a dentist of your choice.
- You can cover yourself and eligible dependents.
- Coverage begins on your first day of work if you enroll within 31 days of your date of hire.

You pay for your coverage with pre-tax dollars, except that coverage for a same-sex domestic partner and his or her eligible dependent children are paid for with after-tax dollars.

Eligibility

EMPLOYEES

You are eligible to participate in this Plan if you are an hourly employee at the Green River, Wyoming facility represented by a collective bargaining agreement between Genesis Alkali, LLC (Successor in interest to Tronox Alkali) and the United Steelworkers Local 13214.

Independent contractors and employees classified as seasonal, temporary or leased are not eligible to participate in this Plan.

Note: In accordance with federal law, Genesis Alkali will not use genetic information to determine eligibility for coverage or to set premiums or contribution rates.

DEPENDENTS

You can enroll your eligible dependents in the Plan if you enroll yourself. Your eligible dependents include:

- Your spouse (if you are not legally separated); or
- Your same-sex domestic partner; and
- Your eligible children up to

age 26. Eligible children include:

- Your biological children;
- Your legally adopted children, including children placed in your custody pending adoption;
- Your foster children, which means those children placed with you by an authorized placement agency or by judgment decree or other order of any court of competent jurisdiction;
- Your stepchildren; and
- Your same-sex domestic partner's children (if they are dependent on you for support).

You can enroll any other dependent children who live in your house and depend on you for support (for example, legally dependent grandchildren); these children are considered dependent on you for support if they can be claimed as dependents on your federal tax return.

You will need to provide verification of your dependent's eligibility and submit the required documentation to the Genesis Alkali Benefits Service Center.

Same-Sex Domestic Partners

You can enroll your same-sex domestic partner for coverage if he or she becomes a certified same-sex domestic partner by signing an *Affidavit of Same-Sex Domestic Partnership*. You can enroll your certified same-sex domestic partner and his or her eligible dependent children if you enroll yourself.

To become certified, you and your same-sex domestic partner must sign an affidavit that states that you and your same-sex domestic partner:

- Are both at least 18 years of age;
- Have lived together continuously in the same household for at least six months and intend to do so indefinitely;
- Are not legally married to one another or anyone else;
- Do not have another certified domestic partner and have not signed an *Affidavit of Same-Sex Domestic Partnership* with another domestic partner or an *Affidavit of Termination of Same-Sex*

Domestic Partnership within the last six months;

- Are mentally competent to consent to a contract or affidavit;
- Are not related by blood in such a way as would prohibit legal marriage; and
- Are jointly responsible for each other's common welfare and are financially interdependent.

An *Affidavit of Same-Sex Domestic Partnership* must be completed, notarized and submitted to the Genesis Alkali Benefits Service Center with any other required documents to enroll a certified same-sex domestic partner.

Domestic partners are subject to the same Genesis Alkali benefit policies as other employees. For example, employees must enroll a new same-sex domestic partner and his or her eligible dependent children in Genesis Alkali's health benefits within 31 days of the date of eligibility.

You agree to inform the Genesis Alkali Benefits Service Center in the event that your domestic partnership terminates by completing and submitting an *Affidavit of Termination of Same-Sex Domestic Partnership*.

Qualified Medical Child Support Order

A state court or agency can require you to provide health care coverage for your eligible dependent child by issuing a Qualified Medical Child Support Order (QMCSO). If a QMCSO is received, your eligible dependent child will be enrolled for the coverage specified in the order. You will also be enrolled if you are not currently enrolled for the coverage listed in the order. Your portion of the cost of coverage will be deducted from your pay.

Generally, a QMCSO should include:

- The name and last known mailing address of the child;
- The type of coverage to be provided; and
- The length of time the order requires the child to be covered.

The order can permit the child's other parent or guardian to file claims on behalf of the child and to receive benefit payments and other information about the coverage, such as ID cards.

You can receive a copy of the QMCSO procedures free of charge from the Genesis Alkali Benefits Service Center at 1-833-251-9452.

If Your Dependent Works for Genesis Alkali

If you and your spouse both work for Genesis Alkali, only one of you needs to enroll for coverage. The spouse who enrolls is able to cover the other as a dependent along with any eligible dependent children. However, the employee enrolled as a dependent will not be eligible for the flex credit for opting-out of medical and/or dental coverage. In addition, you cannot cover your spouse as a dependent if your spouse is enrolled as an employee. If you and your spouse enroll individually, only one of you may cover your eligible dependent children.

If you are an active employee and your spouse retires from employment at Genesis Alkali, your spouse is eligible to be covered as your dependent under the Plan. However, your spouse would forfeit the option of ever enrolling for coverage as a retiree, and would only be eligible for retiree coverage afforded to dependents.

Enrollment - When Coverage Begins

INITIAL ENROLLMENT

As a new employee, your coverage begins on your first day of work if you enroll within 31 days of your hire date.

You can complete your enrollment by going online to www.MyAlkaliBenefits.com or by contacting the Genesis Alkali Benefits Service Center at 1-833-251-9452 within 31 days of your date of hire. If you enroll your dependents at the same time you enroll, their coverage begins when yours does.

If you do not enroll for coverage when first eligible (within 31 days of your date of hire), you can do so during annual enrollment or following a change in family status.

Once you make your elections, they remain in effect for the remainder of the calendar year unless you have a change in family status.

PAYING FOR COVERAGE

You and Genesis Alkali share in the cost of your coverage. You pay your share of the cost on a pre-tax basis. However, if you are covering a same-sex domestic partner and his or her eligible dependent children, your share of their costs are deducted on an after-tax basis. Your payroll deductions are based on several factors including the option you select, who you cover and the number of dependents you enroll.

Pre-tax means that your contributions are deducted from your pay before federal income, Social Security and most state and local taxes are computed (except for Pennsylvania and New Jersey). Using pre-tax dollars lowers your taxable income, so you pay less in taxes for the year. However, your pre-tax contributions may cause a slight reduction in your Social Security benefit at retirement because these contributions reduce the amount of your taxable pay on which your Social Security benefit is based.

If you are enrolling a certified same-sex domestic partner and his or her eligible dependent children, your share of the cost must be made on an after-tax basis. The value of benefits provided to a certified same-sex domestic partner and/or his or her eligible dependent children is considered taxable income. You must pay any state, federal, FICA and other applicable tax withholding in the form of *imputed income*. This amount is based on the value of the coverage Genesis Alkali provides to the certified same-sex domestic partner and his or her eligible dependent children if they are enrolled in coverage.

Payroll deduction amounts are provided with your enrollment materials.

ANNUAL ENROLLMENT

The annual enrollment period is held in the fall of each year. You can enroll, change or cancel coverage at this time. Your annual enrollment coverage elections are effective as of January 1 of the following year.

Once you make your election, your choice remains in effect for the entire calendar year and you cannot change your election until the next annual enrollment period, unless you experience a change in family status.

CHANGE IN FAMILY STATUS – SPECIAL ENROLLMENT EVENT

Once you make your benefit elections, your choices remain in effect for the entire calendar year unless you have a change in family status. A change in family status occurs when you and/or a dependent becomes newly eligible or loses eligibility for coverage. The event that qualifies as a change in family status is referred to as a special enrollment event. If you have a change in family status and want or are required to make a change in your coverage, you must notify the Genesis Alkali Benefits Service Center of the change and provide all required documentation within 31 days of the special enrollment event. If the special enrollment event is the loss of Children's Health Insurance Program (CHIP) or Medicaid coverage

or if you become eligible for employee contribution subsidies from Medicaid or CHIP, you may request enrollment in the Plan within 60 days of the event.

Your new election will be effective the day of the special enrollment event if your change is received within the 31-day or 60-day period, as applicable. If you do not request a change within this period, your next opportunity to do so will be during the annual enrollment period.

Following is a list of special enrollment events that allow you to make changes and the changes you are allowed to make for each event:

Special Enrollment Event	Permitted Changes
Marriage, certified same-sex domestic partnership	Enroll yourself Change Plan option Cancel coverage
Divorce, legal separation, termination of a same-sex domestic partnership or death of a spouse or same-sex domestic partner	Enroll yourself Change Plan option Cancel spouse or same-sex domestic partner coverage
Birth, adoption (or child placed for adoption) or foster child	Enroll yourself Change Plan option
Death of a dependent child	Change Plan option Cancel dependent from coverage
Lose eligibility for benefits due to a change in your, your spouse's, same-sex domestic partner's or dependent's employment status or schedule	Enroll yourself Add dependent(s) to coverage
Gain eligibility for benefits due to a change in spouse's, same-sex domestic partner's or dependent's employment status or schedule	Cancel coverage Cancel dependent(s) from coverage
Loss of a dependent's eligibility due to age	Cancel dependent from coverage
Change in eligibility due to termination of your, your spouse's same-sex domestic partner's or dependent's employer contributions towards	No change allowed
Change in eligibility for benefits due to loss of CHIP or Medicaid coverage	Enroll yourself Add dependent(s) to coverage
Change in eligibility for benefits due to becoming eligible or ineligible for employee contribution subsidies from CHIP or Medicaid	Enroll yourself Change Plan option Cancel coverage
Moving out of network service area	Change Plan option

To make a change go online to www.MyAlkaliBenefits.com or contact the Genesis Alkali Benefits Service Center at 1-833-251-9452. You will be required to provide documentation regarding your status change.

Leaves of Absence

Generally, coverage continues during an approved leave of absence. Contributions for your and your eligible dependents' coverage will continue to be deducted from any pay you receive from Genesis Alkali during a leave of absence (such as short-term disability benefits). If you are not receiving pay from Genesis Alkali during an approved leave of absence or you are receiving income replacement benefits from a third party (such as long-term disability or workers' compensation), you will receive a monthly invoice from the Genesis Alkali Benefits Service Center for your and your eligible dependents contributions. If you do not pay the required contributions during your leave of absence, subject to notice by Genesis Alkali and applicable law, your and your eligible dependents' coverage will be canceled.

If your and your dependents' coverage is canceled due to non-payment while you are on an approved leave of absence, you may reinstate your coverage when you return to work. Your request for reinstatement must be received by the Genesis Alkali Benefits Service Center within 31 days of your return to work and you must pay any required premiums. Your coverage will be effective on the date you return to work if you request reinstatement within 31 days.

Note: For all types of leaves of absence, child means a biological child, adopted child, foster child, step child, legal ward or child of a person standing in loco parentis (meaning acting in place of a parent). Depending on the type of leave and the circumstances, an age limit may apply.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

FMLA provides you with certain rights to a leave of absence and protects your job for the duration of the approved leave (FMLA leave). After having been employed with Genesis Alkali for at least 12 months and at least 1,250 hours of service during the 12-month period immediately before the beginning of the leave, you may be eligible for an FMLA leave of up to 12 work weeks:

- For the birth or placement for adoption or foster care of your child and to care for him/her after the event;
- To care for your spouse, son, daughter or parent who has a serious health condition;
- If you have a serious health condition (including pregnancy) that makes you unable to perform your job; or
- To address certain qualifying exigencies due to your spouse, son, daughter or parent being on covered active duty (or being notified of an impending call or order to covered active duty) in the U.S. Armed Forces. Qualifying exigencies include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions and attending post-deployment reintegration briefings.

  Covered active duty includes certain military duty performed by members of reserve components (i.e., National Guard and Reserves) and members of regular components of the U.S. Armed Forces. Generally, covered active duty is limited to duty during deployment to a foreign country.

  In addition, if you are the spouse, son, daughter, parent or next of kin of a covered service member, you may be eligible for up to 26-weeks of leave during a single 12-month period to care for the covered service member with a serious injury or illness. Certain current and temporary disability retired list members as well as veterans of the U.S. Armed Forces, including the National Guard and Reserves) may qualify as covered service members. To qualify as a covered service member, an individual must be undergoing medical treatment, recuperation or therapy, or must be on status, for a serious illness or injury incurred or aggravated in the line of duty on active duty. For a veteran, the individual must have been a member of the Armed Forces sometime within five years before the date on which the veteran

undergoes the medical treatment, recuperation or therapy.

If you choose not to participate in the Plan while on an FMLA leave, or if your coverage is cancelled due to non- payment while you are on FMLA leave, but you subsequently return to active working status on or before the expiration of your FMLA leave, you and any eligible dependents are immediately eligible for reinstatement. However, you must request reinstatement from the Genesis Alkali Benefits Service Center within 31 days of your return to work and you must pay any required premiums. Your coverage will be effective on the date you return to work if you request reinstatement within 31 days.

MILITARY LEAVE

If you are absent from employment with Genesis Alkali due to being in uniformed service, as defined by the Uniformed Services Employment and Reemployment Rights Act (USERRA), you can continue your healthcare benefits for you and your family for up to 24 months. You pay the current payroll deductions for the first 270 days of your leave and then 102% of the full cost of coverage for the remainder of your leave. If your Plan coverage ends due to your USERRA leave and is later reinstated within the relevant period allowed by USERRA, you will not be subject to any initial eligibility requirements. Refer to Genesis Alkali's Military Leave Policy for more information.

LONGEVITY LEAVE

Longevity Leave is available on a one-time basis to employees with 20 or more years of service. Coverage continues for you and your eligible dependents while you are on Longevity Leave as long as your payroll contributions are paid. If your coverage is canceled due to non-payment while you are on Longevity Leave, you may reinstate your coverage when you return to work. Your request for reinstatement must be received by the Genesis Alkali Benefits Service Center within 31 days of your return to work and you must pay any required premiums. Your coverage will be effective on the date you return to work if you request reinstatement within 31 days.

When Coverage Ends

Coverage under the Plan ends on the last day of the month after the earliest of when:

- Your employment with the Company ends or you retire from the Company (***Note:*** *If you retire early, before age 65, you may continue dental coverage for yourself and your eligible dependents until you reach age 65; you will be required to pay the full cost of this coverage for you and your dependents.* ***Eligible dependents under the Genesis Alkali Retiree Dental Plan are different from active dental coverage. Dependent adult children older than age 23, same-sex domestic partners and children of your same sex-domestic partner are not eligible for coverage under the Genesis Alkali Retiree Dental Plan.*** *Your spouse and/or dependent(s) must be covered under Genesis Alkali active dental coverage on the last day of your active employment with Genesis Alkali to be eligible to enroll in Genesis Alkali retiree dental coverage. If you get married after you retire, your new spouse or any other new dependents are not eligible for Genesis Alkali retiree dental coverage.)*;
- You no longer qualify as an eligible employee of the Company;
- You stop making the required contributions; or
- The Plan ends.

Your dependent's coverage ends when your coverage ends or at the end of the month they are no longer eligible dependents, if earlier.

COBRA Continuation Coverage

Under the *Consolidated Omnibus Budget Reconciliation Act (COBRA)* of 1985, as amended, you and/or your dependents may continue coverage when certain events occur that would otherwise cause your and/or your dependents' coverage to end. The type of qualifying event will determine who is eligible to elect *COBRA* – you, your spouse and your eligible dependent children – and for how long coverage can continue. Domestic partners and their dependent children are excluded from the legal definition of a qualified beneficiary under federal *COBRA* law and are not eligible for continuing coverage under *COBRA*.

You can continue the same level of coverage you had before your coverage ended under the Plan.

You pay the full cost of *COBRA* coverage plus an administrative fee. You and your dependent(s) will have 60 days from the date of the qualifying event or the date the *COBRA Administrator* mails you the *COBRA* election notice, whichever is later, to elect *COBRA* coverage. Once elected, you have 45 days to make your first *COBRA* payment. Thereafter, your premiums are due on the first day of each month.

Note: If you lose coverage because of a "qualifying event," you may be eligible to continue participation in the Health Care Flexible Spending Account to the end of the current calendar year if you elect *COBRA* continuation coverage.
By continuing your coverage, you will be able to incur and submit claims after your termination date and avoid forfeiting unused amounts in your Account. *COBRA* continuation coverage is not available for a Dependent Day Care Flexible Spending Account.

OVERVIEW

Coverage continues for:	If coverage ends because:	Who can elect *COBRA* coverage:
Up to 18 months	• Your employment with Genesis Alkali ends (for reasons other than for gross misconduct); or • You are no longer an eligible employee due to a reduction of	• You • Your spouse • Your eligible dependent children
Up to 29 months	• You or a dependent are determined to be permanently disabled according to the Social Security Administration during the first 60 days of *COBRA* continuation coverage and the disability lasts until the end of the initial 18-month period of *COBRA*	• You • Your spouse • Your eligible dependent children
Up to 36 months	• You die; • You and your spouse divorce or legally separate; or • You become entitled to *Medicare* (*Part A, Part B* or both)	• Your spouse • Your eligible dependent children
Up to 36 months	• Your child loses eligibility for coverage	• Your eligible dependent children

QUALIFYING EVENTS

As an employee, you have the right to elect *COBRA* if you lose your coverage because:

- Your hours of employment are reduced and you no longer qualify as an eligible employee; or
- Your employment ends for any reason other than for your gross

misconduct. Your spouse will have the right to elect *COBRA* if

coverage is lost because:

- You die;
- Your hours are reduced resulting in a loss of eligibility;
- Your employment ends for any reason other than gross misconduct;
- You become entitled to *Medicare* (*Part A, Part B* or both); or
- You divorce or legally separate from your spouse.

Your eligible dependent children will have the right to elect *COBRA* if coverage is lost because:

- You die;
- Your hours of employment are reduced and you no longer qualify as an eligible employee;
- Your employment ends for any reason other than for your gross misconduct;
- You become entitled to *Medicare* (*Part A, Part B* or both);
- You divorce or legally separate; or
- The child loses eligibility as a "dependent" (for example, he or she reaches age 26).

ELECTING COBRA

In most cases, you or your dependents will automatically receive a *COBRA* election notification form the Genesis Alkali Benefits Service Center when you experience a qualifying event. Complete the form according to the directions and return it to the Genesis Alkali Benefits Service Center.

It is you or your family's responsibility to notify the Genesis Alkali Benefits Service Center at 1-833-251-9452, within 30 days of an event that qualifies you and/or a covered family member for *COBRA*, such as a divorce or legal separation.

Each qualified beneficiary (eligible dependent) has a separate right to elect *COBRA* continuation coverage. For example, your spouse may elect *COBRA* continuation coverage even if you do not. *COBRA* continuation coverage may be elected for only one, several or all eligible dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect *COBRA* continuation coverage, you should consider that if you do not continue group health coverage, this will affect your future rights under federal law. For example:

- You may be subject to a pre-existing condition exclusion by another group health plan if you have more than a 63-day gap in health coverage.
- You may lose the right to purchase an individual health insurance policy that does not impose a pre-existing condition exclusion if you do not elect *COBRA* continuation coverage for the maximum time available to you.

You have rights under federal law to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. You also have the same special enrollment right at the end of *COBRA* continuation coverage if you elect *COBRA* continuation coverage

for the maximum time available to you.

COST OF COBRA

You and/or your dependents are required to pay the full cost (employee and employer contribution) of *COBRA*
continuation coverage plus a 2% administrative fee. Payment amounts are indicated on your election form.

After you elect *COBRA* coverage, you have 45 days to make your first payment. Thereafter your payments are due on the first day of each month with a 30-day grace period. Coverage for that month will be provided if payment is received before the end of the grace period. Your claims may not be processed until your payment is received.

If you do not make your payments before the end of the grace period, your *COBRA* continuation coverage will be canceled and you will lose your right to *COBRA* continuation coverage.

HOW LONG COBRA LASTS

The maximum *COBRA* continuation coverage period is:

- 18 months if you lose coverage due to the end of your employment or reduction in hours of employment;
- 36 months if your dependents lose coverage due to your death, divorce, legal separation, entitlement to *Medicare*
  benefits or if your dependent child no longer meets the Plan's definition of a dependent.

If the qualifying event is the end of your employment or reduction of your hours of employment, and you become entitled to *Medicare* benefits less than 18 months before the qualifying event, *COBRA* continuation coverage for your qualified beneficiaries lasts until 36 months after your date of *Medicare* entitlement.

Disability Extension

If you or any one of your covered dependents is determined by the Social Security Administration (SSA) to be disabled and you notify the Genesis Alkali Benefits Service Center within 60 days of the determination, you and your dependents may be entitled to an additional 11 months of *COBRA*, for a total of 29 months. The disability would have to have started at some time before the 60th day of *COBRA* and be expected to last until the end of the initial 18-month period. If the qualified beneficiary is determined by the SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination. The cost of this extended disability *COBRA* coverage could be as much as the full cost (employee and employer contribution) of *COBRA* continuation coverage plus 50%.

Second Qualifying Event

If your spouse and dependent child have a second qualifying event while covered by *COBRA*, their coverage may be extended from 18 months to a total of 36 months measured from the initial loss of coverage. To be eligible for this extension, you or your dependents must notify the Genesis Alkali Benefits Service Center within 30 days from the second qualifying event. An event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

WHEN COBRA COVERAGE ENDS

Generally, *COBRA* will continue for up to 18, 29 or 36 months depending on the qualifying event that caused the loss of coverage. However, coverage can end earlier if:

- Any required premium in not paid in full on time;
- You or your dependents becomes covered, after electing *COBRA* continuation coverage, under another group health plan that does not impose any pre-existing exclusion for your or your dependent's pre-existing condition;
- You or your dependent becomes entitled to *Medicare* (*Part A, Part B* or both) after electing *COBRA* continuation coverage; or
- Genesis Alkali no longer provides any group health plans for its employees.

CONTACTING THE COBRA ADMINISTRATOR

If you need more information or have questions about *COBRA* continuation coverage,

contact: 1-833-251-8452

Be sure to keep the Genesis Alkali Benefits Service Center informed of any address changes to ensure you receive information about this coverage.

For more information about your rights under ERISA, including *COBRA*, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa.

How the Dental Plan Works

YOUR CHOICES

You have the following coverage options under the Plan:

- A low *deductible* option;
- A high *deductible* option; and
- A no coverage option. You may decline dental coverage (opt-out) and receive flex credit of $5 per month in your paycheck as taxable income. You are not eligible for this flex credit if you decline individual coverage but are enrolled as a dependent under your spouse's coverage. If you opt-out of dental coverage, you can enroll during any annual enrollment period or within 31 days following a change in family status.

The Plan's dental options offer the same dental services, including preventive and diagnostic, basic, major services and orthodontia for children. The options differ in what you pay for the coverage, as described in the following section.

WHAT YOU PAY FOR COVERAGE

What you pay for dental coverage includes:

- Your payroll deductions;
- Calendar year *deductibles*;
- Your *coinsurance* payments; and
- Costs in excess of maximum benefit limits.

Payroll Deductions

You and Genesis Alkali share in the cost of your dental coverage. Your payroll deductions are based on the option you select and the number of dependents you cover.

Options with higher *deductibles* cost less than options with lower *deductibles*. Employees covering dependents pay more than employees electing single coverage.

Your monthly payroll deductions for the five-year term of the current labor agreement are as follows:

	1/1/2017		1/1/2018		1/1/2019	
Deductible Option	**$50**	**$100**	**$50**	**$100**	**$50**	**$100**
Employee	$8.80	$2.04	$9.24	$2.09	$9.75	$2.15
Employee + 1	$17.08	$5.10	$17.93	$5.23	$18.92	$5.38
Family	$25.36	$7.14	$26.63	$7.32	$28.09	$7.54

Calendar Year Deductible

A *deductible* is the amount of covered expenses you pay before the Plan pays benefits. After the *deductible* is met, the Plan pays a percentage of covered expenses for the remainder of the calendar year.

The calendar year *deductible* applies to each family member. However, there is a family *deductible* maximum. Once the family *deductible* maximum is met, the Plan pays benefits at the appropriate

percentage for the type of care received for all family members for the remainder of the calendar year.

Coinsurance

Coinsurance is the percentage of the charges you pay after you meet your *deductible*. The percentage you pay depends on the coverage option you select and the type of dental service.

Maximum Benefits

The Plan includes:

- An annual maximum benefit, which is the maximum amount the Plan will pay per person each year for covered preventive, basic and major services; and
- A lifetime maximum benefit, which is the maximum amount the Plan will pay per child younger than age 19 for orthodontia covered expenses.

These maximums are listed in the following section.

SCHEDULE OF BENEFITS

Provision	Low *Deductible* Option	High *Deductible* Option
Deductible (applies to basic, major and orthodontia dental services)	$50 per person; $100 family maximum	$100 per person; $200 family maximum
Coinsurance		
Preventive (cleaning, routine exam, X-ray, fluoride for children, *emergency dental*	Plan pays 100%; no *deductible* (limited to annual maximum)	Plan pays 100% no *deductible* (limited to annual maximum)
Basic Services (filling, extraction, oral surgery, endodontics,	After *deductible*, Plan pays 80% (limited to annual maximum)	After *deductible*, Plan pays 70% (limited to annual maximum)`
Major Services (bridge, denture, crown, replacing damaged appliance, with limitations, inlay, onlay, gold restoration)	After *deductible*, Plan pays 50% (limited to annual maximum)	After *deductible*, Plan pays 40% (limited to annual maximum)
Orthodontia	After *deductible*, Plan pays 50% (limited to lifetime	After *deductible*, Plan pays 50% (limited to lifetime
Benefit Maximums		
Annual (applies to preventive, basic and major dental services combined)	$2,100 per person	$1,500 per person
Lifetime (applies to orthodontia)	$2,000 per child younger than age 19	$2,000 per child younger than age 19

HOW THE PLAN WORKS

- The Plan pays a percentage of the *reasonable and customary charges* for covered basic, major and orthodontia dental services after your applicable calendar year *deductible* (individual and/or family) is met; the *deductible* does not apply to preventive services.
- The Plan pays up to the maximum benefit limit each calendar year for each covered person.
- Orthodontia services for children have a separate lifetime maximum limit.

MAJOR DENTAL AND ORTHODONTIA SERVICES WAITING PERIOD

If you do not enroll in the Plan when you and/or your dependents are first eligible, there is a six-month waiting period before major dental and orthodontia services are covered; regardless of the *deductible* option you elect. This means that you and/or your dependents will not receive coverage for any major dental or orthodontia services for the first six-continuous month period that you are covered under the Plan. This six-month waiting period also applies if you drop coverage for any reason and subsequently re-enroll; you and/or your family will have to satisfy the six- month waiting period before being covered for major dental and orthodontia services.

PREFERRED DENTISTS

You can use any dentist you choose for services. However, using dentists who are part of the Plans PPO or Premier networks of dental providers helps you reduce your out-of-pocket costs. Network dentists have agreed to charge specified fees for their services. These fees are within *reasonable and customary* guidelines and are generally lower than what other dentist charge so your costs are less.

To find a network dentist, go online to www.deltadentalins.com or call the Member Services at the number on your ID card.

PRE-TREATMENT ESTIMATE

When the cost of a recommended treatment plan exceeds $500, you should obtain a pre-treatment estimate. This process helps you know in advance how much the Plan will pay for your dental work. Most dentists are familiar with this process. Here is how it works:

- Your dentist submits a treatment plan to the *Claims Administrator* outlining the services to be provided, x-rays and the costs.
- The *Claims Administrator* reviews the treatment plan and notifies you and your dentist how much the Plan will pay.
- You should review this estimate with your dentist before starting any dental work.

Any changes to the treatment plan after the pre-treatment estimate has been received may change the amount the Plan will pay. If there are major changes to the treatment plan, a new estimate should be obtained.

ALTERNATE PROCEDURES

There is often more than one way to treat a dental problem. To determine what the Plan will pay, the *Claims Administrator* will consider the least costly services or supplies that are appropriate and meet acceptable national dental standards to treat your dental needs. If you decide you want a more expensive treatment, you are responsible for any additional charges.

Covered Dental Services

The amount the Plan pays for dental services depends on the coverage option you elect and the *deductibles*, *coinsurance* and maximum benefits of that option, as shown in the Schedule of Benefits. However, regardless of the option you choose, the same dental services are covered, as described in this section.

PREVENTIVE AND DIAGNOSTIC SERVICES

Covered preventive and diagnostic services include:

- Routine oral examinations – up to two per calendar year;
- Cleaning and scaling of the teeth (prophylaxis) – up to two times per calendar year;
- Topical application of fluoride for a child younger than age 19 – up to two times per calendar year;
- X-rays for diagnosis. Also other x-rays not to exceed one full mouth series in a 36-month period and two sets of bitewings each calendar year;
- Sealants – for children younger than age 16 for molars and bicuspids, not to exceed one application in any three- year period;
- Space maintainers – for children younger than age 19 when needed to preserve space resulting from premature loss of primary teeth; and
- Palliative *emergency dental treatment*.

BASIC DENTAL SERVICES

Covered basic dental services include:

- Fillings;
- Bridgework and denture repair and maintenance;
- Denture reline or rebase, limited to once in a 36-month period;
- General anesthesia when *medically necessary* and administered in connection with dental surgery;
- Extractions;
- Periodontics (treatment for gum disease); and
- Endodontics (pulp infection and root canal therapy).

MAJOR DENTAL SERVICES

Note: *Coverage for these services may be subject to a six-month waiting period, see the Major Dental and Orthodontia Services Waiting Period section.*

Covered major dental services include:

- Bridges and dentures;
- Initial installation to replace extracted teeth that were not abutments to a denture or bridge less than five years old while covered by the Plan (replacement of existing bridges or dentures is limited once every five years);
- Replacement dentures or bridgework;
- To add teeth extracted if the:
  - Existing denture or bridgework is at least five years old and cannot be made serviceable; or
  - Existing denture is an immediate temporary denture that cannot be made permanent and the replacement denture is placed within 12 months from the date of the initial temporary denture;
- If you have a natural tooth or teeth that are missing and need to be replaced, the first set of complete dentures, removable partial dentures, fixed partial dentures (bridges) and prosthetic services are covered only if the natural tooth or teeth were removed while you are covered by the Plan; and
- Crowns, inlays, onlays or gold fillings but only if the teeth cannot be restored with fillings.

Major dental services are subject to the replacement rules, which include, but are not limited to, providing proof and replacement no more frequent than once every five years.

ORTHODONTIA SERVICES

Note: *Coverage for these services may be subject to a six-month waiting period, see the Major Dental and Orthodontia Services Waiting Period section.*

Covered services include a dentist's orthodontic treatment for a child younger than age 19. Additionally, the first appliance must be installed after the child is covered by this Plan for these services.

Payments for orthodontic services are made over the course of the treatment period and not in a lump sum at the beginning of treatment. The Plan pays 50% of the approved charge upon receipt of a claim for services rendered; the remainder of the charge is divided equally over the number of months of the treatment plan and paid in quarterly installments.

If your dependent stops orthodontic treatment for any reason before it is complete, the Plan will only cover services and supplies actually received. Orthodontia benefits end when your dependent reaches age 19 or when coverage ends. There are no provisions for the continuation of treatment after age 19.

INCURRING EXPENSES

You are considered to incur a charge for dental treatment on the date you are treated, except that a charge is considered incurred for:

- Dentures and bridgework, as of the date the impression is made;
- Crowns, as of the date the tooth is prepared;
- Root canal therapy, as of the date the treatment begins; and
- Orthodontics, as of the day the first appliance is installed for active treatment.

Limitations and Exclusions

Some expenses are not covered by the Plan. Expenses not covered include:

- Charges in excess of *reasonable and customary charges*.
- Services other than those specifically listed as being covered by this Plan.
- Charges for plastic surgery, reconstructive surgery, cosmetic surgery or other services or supplies that improve, alter or enhance appearance, whether or not for psychological or emotional reasons.
- Replacement of lost or stolen dentures, bridgework or other appliances.
- Dental expenses for a work-related injury or illness.
- Services or supplies provided, paid for or for which benefits are provided or required due to the past or present service of an individual in the armed forces of the government, unless payment is legally required.
- Services or supplies provided, paid for or for which benefits are provided or required under any government law unless payment is legally required.
- Charges you are not legally obligated to pay.
- Charges for claim form processing or broken appointments.
- Services, supplies or treatments that do not meet the standards of dental practice accepted by the American Dental Association or considered experimental or investigational.
- Charges for care, treatment, services or supplies that are not prescribed, recommended or approved by the individual's attending *physician* or dentist.
- Charges for acupuncture therapy, except when performed by a *physician* as a form of anesthesia in connection with surgery that is covered.
- Treatment by someone other than a dentist, except for a licensed dental hygienist supervised by a dentist.
- Charges for services or supplies not necessary, as determined by the *Claims Administrator*, for the diagnosis, care or treatment of the disease or injury involved.
- Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
- Treatment given by a member of your immediate family or your spouse's immediate family.
- Services that are covered by the Genesis Alkali Health Care Plan.
- Charges for duplicate prosthetic devices or any other duplicate appliances.
- Charges for local anesthesia and nitrous oxide unless included in the *reasonable and customary charge* for the particular dental procedure.
- Services beyond the scope of the dentist's license.
- Charges for training or supplies used to educate people on the care of their teeth.
- Periodontal splinting, tooth transplantation and tooth implants.
- Porcelain veneer crowns and pontics placed on or replacing a molar, except to the extent acrylic veneer crowns are covered.
- Orthodontic services and supplies for any individual age 19 or older.

- Charges for services incurred before being covered by this Plan.
- Temporomandibular disorder (TMD) treatment and temporomandibular joint (TMJ) therapy.
- Sedative or temporary fillings.
- Any sales or other taxes, service or interest charges.
- Dentures, crowns, inlays, onlays, bridges or other appliances or services used for splinting, altering vertical dimension, restoring occlusion or correcting attrition, abrasion or erosion.
- Dental services and supplies covered, in whole or in part, under any other plan.
- First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to abutment, to replace congenitally missing teeth or to replace teeth lost before coverage began.
- Space maintainer except when needed to preserve space resulting from the premature loss of deciduous teeth (i.e., teeth that fall out at maturity).

Filing a Claim

You must file a claim for reimbursement of covered expenses. To file a claim, obtain a dental service report, available at your work location, by calling Member Services or online at www.deltadentalins.com. Complete the form according to the instructions and send it along with original receipts to the address listed on the report.

Your dentist can also use a standard claim form if it includes the following information:

- Your name and the patient's name;
- Name, address and phone number of the provider;
- A description of service performed;
- The date the service was provided; and
- The amount charged.

CLAIM SUBMISSION DEADLINES

All claims should be submitted as soon as possible. Claims submitted 12 months after the date of service are not eligible for reimbursement.

IF YOUR CLAIM IS DENIED

If your claim is denied (in whole or in part), you and the treating Dentist will receive an Explanation of Benefits (sometimes referred to as an Adverse Benefit Determination), within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 15 days, for processing.

If an extension is necessary, you and the treating Dentist will be notified of the extension and the reason it is necessary within the original 30 day period. If an extension is taken because either you or the Dentist did not submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

EXPLANATION OF BENEFITS FORM

- The processing policy or policies (numerical code(s)) stating the specific reason(s) why the claim was denied, including a reference to specific plan provisions on which the denial is based; whether a specific rule, guideline or protocol was relied upon in making the Adverse Benefit Determination and if so, that a copy will be provided free of charge upon request; and a description of any additional information needed in order to perfect the claim as well as the reason why such information is necessary;
- Reference in the processing policy or policies to the relevant scientific or clinical judgment, if the Adverse Benefit Determination is related to dental necessity, experimental treatment or other similar exclusion or limitation;
- A description of the Plan's review procedures and the time limits applicable to these procedures;
- A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, after you have exhausted all of your appeals under the Plan.

If your claim is denied (in whole or in part), you may appeal the decision under the procedures described in the next section.

Appeal Procedures

If a claim is denied in whole or part, Delta Dental shall notify you and the treating dentist of the denial in writing, issuing an Explanation of Benefits (sometimes referred to as an Adverse Benefit Determination). To request an Informal Review, you or the billing Dentist may submit a request within sixty (60) days of the mailing date of the Adverse Benefit Determination. To request an Appeal of the Adverse Benefit Determination, you may appeal the determination within 240 days following the mailing date of the original Adverse Benefit Determination.

For **eligibility** appeals:
Genesis Alkali, LLC Human Resources
Genesis Alkali, LLC
1735 Market Street
Philadelphia, PA

19103 For **dental**

reviews:

Delta Dental
Attn: Review Department
P.O. Box 2105
Mechanicsburg, PA 17055
1-800-932-0783

For **dental** appeals:
Delta Dental
Attn: Formal Appeals Department
P.O. Box 2105
Mechanicsburg, PA 17055
1-800-932-0783

INFORMAL REVIEW

If you or your billing Dentist disagrees with the Adverse Benefit Determination, either may within sixty (60) days of the mailing date of the Adverse Benefit Determination, deliver a request to Delta Dental for informal review of the Adverse Benefit Determination. The procedure to submit is explained on the reverse side of the Explanation of Benefits form. Delta Dental will issue its decision on the Informal Review within 60 days after receipt of the Informal Appeal.

Information to be provided for the Informal Review includes:

(a) Dentist name, office name, address and license number
(b) Member name, Member ID number (which in many cases is the primary subscriber's social security number)
(c) Patient name and date of birth
(d) Claim number
(e) Request is for an informal review
(f) Description of the reasons why Delta Dental should change its initial decision on the claim and the specific decision which you request
(g) Any supplemental information or diagnostic materials relevant to the claim in question
(h) In lieu of (a), (b), (c) and (d), attach a copy of the claim and the claim determination you are appealing

A form is available for you to use at http://www.deltadentalpa.com/HIPAA/lawcompliance.shtml.

You must sign your request.

APPEAL

If you disagree with Delta Dental's Adverse Benefit Determination, you may appeal the determination within 240 days following the mailing date of the original Adverse Benefit Determination. The appeal must be in writing and must state why it is believed that Delta Dental's decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. Delta Dental's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by you, regardless of whether such information was submitted or considered in the initial benefit determination.

Information to be provided for the Appeal includes:

(a) Dentist name, office name, address and license number
(b) Member name, Member ID number (which in many cases is the primary subscriber's social security number)
(c) Patient name and date of birth
(d) Claim number
(e) Request is for an appeal
(f) Description of the reasons why Delta Dental should change its initial decision on the claim and the specific decision which you request
(g) Any supplemental information or diagnostic materials relevant to the claim in question
(h) In lieu of (a), (b), (c) and (d), attach a copy of the claim and the claim determination you are appealing

A form is available for you to use at http://www.deltadentalpa.com/HIPAA/lawcompliance.shtml.

You must sign your request.

DELTA DENTAL's REVIEW

The Delta review shall be conducted by a person who is neither the individual who made the initial claim denial not the subordinate of such individual. If the review is of an Adverse Benefit Determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the person who made the initial claim denial nor the subordinate of such individual. Delta Dental shall provide upon request of you, the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

REVIEW DECISION

Delta Dental shall notify you in writing of its decision on the Formal Appeal within 30 days of its receipt of the appeal, unless it determines that special circumstances require an extension of time for processing as detailed below. In such cases, written notice of the extension shall be furnished to you prior to the end of the initial 30 day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which Delta Dental expects to render the determination on the appeal.

If Delta Dental upholds the Adverse Benefit Determination on appeal, the notice to you shall include

the following information:

- The processing policy or policies (numerical code(s)) stating specific reason(s) for the adverse determination, with reference to specific plan provisions upon which the determination is based, whether a specific rule, guideline or protocol relied upon in making the determination, and if so, that a copy will be provided free of charge upon request.
- Reference in the processing policy or policies to the relevant scientific or clinical judgment, if the Adverse Benefit Determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.
- A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free of charge upon request.
- Advice that options for further recourse or for obtaining information may include contacting the state regulatory agency or local U.S. Department of Labor office, or bringing a civil action under ERISA.

Coordination of Benefits (COB)

WHEN THERE IS ANOTHER PLAN

To avoid duplicate payments for the same service, the Plan coordinates with other group plans (including *Medicare* or Medicaid) or no-fault automobile insurance plans that provide benefits. Generally, if you or your dependents are covered by more than one plan, your expenses are shared between the two plans. One plan will pay benefits first; this is the primary plan. The other plan(s), the secondary plan, will base payments on the remaining unpaid charges according to its provisions. If this Plan is primary, it will pay regular benefits based on allowable charges. If this Plan is secondary, it will pay the difference between its regular benefits reduced by the amount of the other plan's payment.

A plan is considered "primary" and pays benefits first if:

- It has no *coordination of benefits* provision; or
- It covers the individual as an employee.

For eligible children under the age of 26 covered under more than one parent's plan, the primary plan is:

- The plan of the parent with the earlier birthday in the year; or
- If the parents are divorced or separated:
  - The plan of the parent with financial responsibility for the child if a court order establishes financial responsibility; or
  - The plan of the parent with custody if there is no court order.

If the above rules do not determine which plan is primary, the plan covering the individual the longest is primary. However, note that an individual's *COBRA* continuation coverage is always secondary.

Example

Devon is an employee of Genesis Alkali. His spouse is covered by her employer's plan as an employee and under the Plan as a dependent. His spouse's employer's plan is primary since it covers her as an employee and the Plan is secondary. If she incurs $500 of covered expenses, here is how the plans coordinate benefits:

— The spouse's employer's plan determines, according to its rules, that it will pay $400.

— The Plan, according to its rules, determines that it would have paid $450 if this Plan was primary.

— Since the spouse's plan is primary, the Plan pays $50, which is the difference between its regular benefits ($450) and the amount the spouse's plan pays ($400), or $450 - $400.

In this case, the spouse receives $450 from the two plans combined. If her employer's plan had paid $450 or more, the Plan would not make any payment.

Subrogation and Reimbursement

If you are injured or become ill as a result of the actions or omissions of a third party – and you receive benefits under the Plan for that injury, sickness or condition – you must take all actions necessary to enable the Plan to recover those benefits from the third party, or must reimburse the Plan for any money you received from the third party, up to the amount the Plan has paid. For this section, "you" refers to the covered employee, his or her spouse and/or any covered dependents.

SUBROGATION

When the Plan pays benefits, the Plan is immediately subrogated to (stands in place of) you with respect to your rights of recovery for any other individual or entity, including your insurance company, who may be responsible for compensating you or has agreed to compensate you for the injury, sickness or condition. (This individual or entity is known as the "responsible party.") The Plan's subrogation right applies to the full extent of benefits provided or to be provided by the Plan for any injury, sickness or condition for which you have or may be able to recover from the responsible party.

REIMBURSEMENT

If you have received (or will receive) Plan benefits for any sickness, injury or condition for which you (or your representative, agent, guardian or trust) have received payment from any responsible party or insurance coverage (including automobile or other coverage), the Plan has the right to be reimbursed for the full amount of benefits paid. The Plan may recover from, and be reimbursed by you, your representative, agent, guardian or trust, up to and including the full amount you received or are eligible to receive from any responsible party.

CONSTRUCTIVE TRUST

By accepting benefits from the Plan, you agree that if you (or your representative, agent, guardian or trust) receive any payment from any responsible party due to your injury, sickness or condition, you agree to hold such payment(s) in trust for the Plan, up to the amount of Plan benefits that have been paid or are payable.

LIEN RIGHTS

By providing benefits, the Plan automatically has a priority lien to the full extent of benefits it pays for the sickness, injury or condition for which the responsible party has liability or otherwise has agreed to pay. The lien will be imposed upon any amount recovered, whether by settlement, judgment or otherwise, related to any sickness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who has funds or proceeds related to the amount of benefits paid by the Plan including, but not limited to, you; your representative, agent, guardian, trust or insurer; a responsible party; a responsible party's insurer, representative or agent; and/or any other source having funds related to the amount of benefits the Plan paid.

FIRST-PRIORITY CLAIM

By accepting benefits, you acknowledge and agree that the:

- Plan's recovery rights are a first priority claim against all responsible parties and are to be paid to the Plan before any other claim for damages
- Plan is entitled to full recovery on a first-dollar basis from any responsible party's payments, even if the payment to the Plan will result in a recovery to you that is not enough to make you whole or to compensate you in part or in whole for the damages sustained
- Plan is not required to participate in or pay court costs or attorney fees to any attorney hired

to pursue the damage claim and that you will be solely responsible for the costs and fees.

APPLICABILITY

The rights described in this section apply whether or not any responsible party admits liability for payment and whether or not the settlement or judgment received identifies the benefits the Plan provided, or allocates any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

COOPERATION

You must fully cooperate with the Plan's efforts to recover all amounts paid under the Plan and/or any amounts to which the Plan may be entitled under this section of the SPD. You must notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your (or your representative, agent, guardian, trust or insurer's) intention to pursue or investigate a claim to recover damages or obtain compensation due to any injury, sickness or condition. You and/or your agents, representatives or guardians will provide all information requested by the Plan, Delta Dental or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request.
Failure to provide this information may result in the termination of your benefits or the institution of court proceedings against you.

The Plan may recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, court costs and other expenses. The Plan will also be entitled to reduce any future benefits payable to you under the Plan until you have fully met your reimbursement obligations hereunder.

You must do nothing to prejudice the Plan's subrogation or reimbursement interest or to prejudice the Plan's ability to enforce the terms of this subrogation and reimbursement provision. This includes, but is not limited to, your making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

You acknowledge and agree that the Plan has the right to conduct an investigation regarding the injury, sickness or condition to identify any responsible party. The Plan reserves the right to notify any responsible party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

INTERPRETATION

Delta Dental has the sole authority and discretion to resolve all disputes regarding the interpretation of this subrogation and reimbursement provision including questions about the meaning or intent of any of its terms or whether any part of the provision is ambiguous.

JURISDICTION

By accepting Plan benefits, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting benefits, you and/or your dependent submit to each such jurisdiction, waiving whatever rights may correspond to you based on where you live now or in the future.

Your Privacy Rights

This Plan complies with the privacy and security regulations put into effect under the Health Insurance Protection and Accountability Act (HIPAA). The Plan will not use or disclose your protected health information for purposes other than treatment, payment and Plan administrative functions without your written authorization or as required by law.
The Plan routinely discloses protected health information to insurance companies, *Claims Administrator* and others for contracted health operations services such as paying claims, verifying benefits or conducting audits. All protected health information (which includes genetic information) used, requested or disclosed is limited to the minimum amount necessary to accomplish the intended purposes of the Plan and its administration.

You have the right to inspect and copy, request amendment or correction, restrict the use or disclosure, and request an accounting of the uses and disclosures or your protected health information. A copy of Genesis Alkali's Notice of HIPAA Privacy Practices, which contains a description of the uses and disclosures of protected health information, your privacy rights, the Plan's duties and complaint procedures, is available upon request from the Genesis Alkali Benefits Service Center.

Plan Administrative Information

This section contains important information about the Plan that is described in this SPD. In this section, you will find information about the Plan and your legal rights.

PLAN NAME

This SPD describes the Dental Plan of the Genesis Alkali Welfare Benefits Program.

PLAN SPONSOR

The Plan is established and maintained by the Plan Sponsor,

which is: Genesis Energy, LLC
919 Milam Street
Suite 2100
Houston, TX 77002
1-713-860-2500

PLAN ADMINISTRATOR

The *Plan Administrator* is:
Genesis Energy, LLC
919 Milam Street
Suite 2100
Houston, TX 77002
1-713-860-2500

CLAIMS ADMINISTRATOR

The *Claims Administrator* is:
Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055
1-800-932-0783

EMPLOYER IDENTIFICATION NUMBER

47-2173866

PLAN NUMBER

504

AGENT FOR SERVICE OF LEGAL PROCESS

If you feel you have cause for legal action against the Plan, you may serve legal process on the *Plan Administrator* or Genesis Alkali's agent for legal services at:

C.T. Corporation Systems
1209 Orange Street
Wilmington, DE 19801

PLAN YEAR

The *plan year* is the same as the calendar year, which is from January 1 through December 31 each

year.

PLAN TYPE

This is a welfare plan providing dental coverage.

PLAN FUNDING

This Plan is fully insured and benefits are provided through an insurance contract. Premiums are paid with employees' payroll deductions and contributions from Genesis Alkali's general assets.

FALSE OR FRAUDULENT CLAIMS

Any person who knowingly submits a false or fraudulent claim for benefits under the Plan is guilty of a serious offense, which may lead to disciplinary action, up to and including termination of employment, as well as criminal prosecution.

MISSTATEMENT OF AGE

If a covered individual's age is misstated, benefits will be adjusted to the amounts that would have been eligible based on the correct age.

INCONTESTABILITY

All statements made by Genesis Alkali or an insurance company are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the document containing the statement has been provided to you. If you die or become legally incapacitated, your beneficiary or representative will receive the copy.

After two years from the effective date of coverage, or from the effective date of any added or increased benefits, no statement that you make will cause your benefits to be questioned, except when there is a question of fraud or your or your covered dependent's eligibility to participate in the Plan.

WORKERS' COMPENSATION INSURANCE

Plan coverage does not replace and does not affect any requirements for insurance under any *workers' compensation*
insurance law.

PLAN CHANGES AND TERMINATIONS

Genesis Alkali expects to continue the Plan described in this SPD, but reserves the right to terminate or amend the Plan, in whole or in part, at any time for any reason at its sole discretion. In addition, contributions for coverage may be changed from time to time without prior notice, unless specific rates have been negotiated for by the terms of a collective bargaining agreement. You will be notified in writing of any changes to the Plan.

If the Plan is terminated, you will not receive any further Plan benefits except for payment of a loss or expenses incurred before the Plan ended.

PLAN INTERPRETATION

Genesis Alkali and the *Plan Administrator* have delegated to the *Claims Administrator* discretionary authority to interpret Plan provisions, determine benefit payments and make final and binding decisions about initial claims. The *Claims Administrator* has discretionary authority over all appeals of denied claims. All appeal determinations made by the *Claims Administrator* will be final and binding.

PLAN DOCUMENTS

This SPD summarizes the key features of the Plan. Complete details of the Plan can be found in the Plan Document (including any applicable contracts) that governs Plan operations. If there is a conflict between the information in this SPD and the Plan Document, the information in the Plan Document will govern.

Copies of the Plan Document, as well as the Plan's latest annual reports and SPDs are available for review any time during normal work hours from your human resources department.

If the Plan is maintained pursuant to a collective bargaining agreement, a copy of the agreement is available, upon written request, from the *Plan Administrator*.

Your ERISA Rights

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

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at Genesis Alkali's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to Genesis Alkali, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. Genesis Alkali may assess a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. Genesis Alkali is required by law to furnish each participant with a copy of this summary annual report.

To obtain copies of the documents listed above, write the office of Benefits Director, Genesis Alkali, LLC, 1735 Market Street, Philadelphia, PA 19103.

CONTINUE PLAN COVERAGE

You also have the right to:

- Continue coverage for yourself and your eligible dependents if there is a loss of coverage because of a qualifying event. You or your dependents may have to pay for this coverage.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under the Plan if you have creditable coverage from another plan. You will be provided with a certificate of creditable coverage, free of charge, when:
  - You lose coverage under this Plan;
  - You become entitled to elect *COBRA* continuation coverage; or
  - Your *COBRA* continuation coverage ends.

You may request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called Plan fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision (without charge) and to appeal any denial, all within certain time schedules. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claim and appeal procedures.

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

If you have a claim that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court may decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH QUESTIONS

If you have any questions about the Plan, you should contact the Genesis Alkali Benefits Service Center. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from Genesis Alkali, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) or the national office at:

Division of Technical Assistance and
Inquiries Employee Benefits Security
Administration
U.S. Department of Labor
200 Constitution Avenue
NW Washington, DC
20210
1-866-444-3272

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their Web site at www.dol.gov/ebsa.

Definitions

AFFIDAVIT OF DOMESTIC PARTNERSHIP

A written notarized statement that attests that the employee and the domestic partner meet all the requirements of a domestic partnership.

CLAIMS ADMINISTRATOR

The *Claims Administrator* reviews and determines whether to pay claims. The *Claims Administrator* is designated by the
Plan Administrator to make claims determinations consistent with the provisions of the Plan.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OR COBRA

Federal legislation that outlines the conditions under which you may continue coverage for a limited period if certain events would otherwise cause your coverage to end.

COORDINATION OF BENEFITS OR COB

A method of determining the amount of benefits a plan pays if you are covered by more than one group health plan at the same time. Genesis Alkali uses a *maintenance of benefits* method to coordinate payments with other plans.

COINSURANCE

The percentage of covered expense paid by a plan and by you after any *deductible* or *co-payment* is satisfied. For example, 50% *coinsurance* means a plan would pay 50% of covered expenses after any *deductible* and you would pay the remaining 50% of covered expenses (and your *deductible*, if applicable).

CO-PAYMENT

The dollar amount you pay for covered services to a network provider at the time you receive care.

DEDUCTIBLE

The dollar amount of covered expenses you must pay each calendar year before the Plan pays benefits. After the *deductible* is met, the Plan pays the *coinsurance* percentage of the covered expenses for the remainder of the calendar year. There are two types of calendar year *deductibles* – individual and family.

IMPUTED INCOME

The value of non-cash compensation to an employee's taxable wages to withhold income and employment taxes.

MAINTENANCE OF BENEFITS

A method of coordinating benefit payments when you are covered by more than one health care plan at the same time. Under this method, one plan's payments are reduced so you still pay your applicable *coinsurance* percentage of covered expenses.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

The *Claims Administrator* determines, at its sole discretion, if a service or supply is *medically necessary* and meets the following criteria:

- Required to diagnose or treat an illness, injury, disease or pregnancy;
- Follows generally accepted standards of medical practice;
- Clinically appropriate; and
- There is not a less intensive or appropriate diagnostic or treatment alternative that could have been used.

A determination that a service or supply in not *medically necessary* can apply to the entire service or supply or to any part of it.

MEDICARE

The health care benefit program provided under the Social Security Act, as amended.

MEDICARE PART A

The part of *Medicare* that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.

MEDICARE PART B

The part of *Medicare* that helps pay for doctors, services, outpatient hospital care, durable medical equipment and some medical services that are not covered by *Medicare Part A*.

PHYSICIAN

A legally licensed medical practitioner practicing within the scope of his or her license.

PLAN ADMINISTRATOR

Under ERISA, the *Plan Administrator* is responsible for managing the Plan's assets. This includes acting solely in the interest of Plan participants and beneficiaries and for the exclusive purpose of providing benefits and defraying reasonable administrative expenses. The *Plan Administrator* must act in accordance with all documents governing the Plan at all times.

PLAN YEAR

The calendar year, January 1 through December 31, on which the records of this Plan are kept.

REASONABLE AND CUSTOMARY (R&C) CHARGE

A charge for medical treatment, service or supply that is within the normal range of charges made by most *physicians*, hospitals and other health care providers in the same geographical area for the same treatment, service or supply.

WORKERS' COMPENSATION

The group of state and federal laws providing benefits to employees for work related injuries or illnesses.