Genesis Alkali, LLC

VISION 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 Vision Plan (Plan). The Plan is administered by Vision Service Plan (VSP) and provides for periodic benefits for routine eye exams and eyewear for you, as an eligible employee, and your eligible dependents.

Benefits described in this SPD are as of September 1, 2017. This SPD replaces and supersedes any previous SPDs regarding the Plan. 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

- Provides for an annual eye exam and prescription glasses (lenses and frames) every 12 months. Contact lenses are available in place of glasses.
- You can cover yourself and your eligible dependents.
- Coverage begins on your first day of work if you enroll within 31 days of your date of hire.
- You can take advantage of the VSP network of optometrists and ophthalmologists and save on out-of-pocket costs or use any qualified provider of your choice.
- Discounts are available on laser vision correction surgery.
- 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 is paid 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 Steel Workers 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 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); 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 1-844-887-6669.

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. 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.

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 to My Benefits online at 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 pay 100% of the cost of coverage 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 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. 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.

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

become newly eligible or lose 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 • Cancel coverage • Add or cancel dependent(s) coverage
Divorce, legal separation, termination of a same-sex domestic partnership or death of a spouse or same-sex domestic partner	• Enroll yourself • Cancel spouse or same-sex domestic partner coverage • Add or cancel dependent(s) coverage
Birth, adoption (or child placed for adoption) or foster child	• Enroll yourself • Add dependent(s) coverage
Death of a dependent child	• Cancel dependent 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) 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) coverage
Loss of a dependent's eligibility due to age	• Cancel dependent coverage
Change in eligibility due to termination of your, your spouse's, same-sex domestic partner's or dependent's employer contributions towards coverage	• No change allowed
Change in eligibility for benefits due to loss of CHIP or Medicaid coverage	• Enroll yourself • Add dependent(s) coverage
Change in eligibility for benefits due to becoming eligible or ineligible for employee contribution subsidies from CHIP or Medicaid	• Enroll yourself • Cancel coverage • Add or cancel dependent(s) coverage

To make a change go to My Benefits online at 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 Employee 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 nonpayment 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;
- 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 hours or employment classification.	• 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* coverage	• 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 from 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:

833-251-9452

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 Vision Plan Works

YOUR CHOICE

You have the option to elect or waive coverage under the Plan. If you do not enroll in vision coverage when you are first eligible, you can enroll during any annual enrollment period or within 31 days following a change in family status.

WHAT YOU PAY FOR COVERAGE

What you pay for vision coverage includes:

- Your payroll deductions;
- Your *co-payments*; and
- Costs in excess of maximum allowances.

PAYROLL DEDUCTIONS

Payroll Deductions

You pay 100% of the cost of coverage. Your payroll deductions are based on who you cover and the number of dependents you enroll.

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

	1/1/2017	1/1/2018	1/1/2019
Employee	$9.25	$9.58	$9.91
Employee + 1	$13.25	$13.71	$14.20
Family	$23.77	$24.61	$25.47

Co-Payment

A *co-payment* is the dollar amount you pay when you receive vision care services. The amount of your *co-payment* depends on the service you receive, as shown in the Schedule of Benefits section.

Maximum Allowance

The Plan includes maximum amounts that will be paid for specific services and supplies. These maximum allowances are shown in the Schedule of Benefits section.

SCHEDULE OF BENEFITS

Service	VSP Network Provider	Non-VSP Provider
Exam (once every 12 months)	Covered in full after $20 *co-payment*	Up to $50 after $20 *co-payment*
Eyewear: Lenses and Frames	***(once every 12 months instead of contact lenses*)***	
Single Vision Lenses	Covered in full after $20 *co-payment*	Up to $50 after $20 *co-payment*
Lined Bifocal Lenses	Covered in full after $20 *co-payment*	Up to $75 after $20 *co-payment*
Lined Trifocal Lenses	Covered in full after $20 *co-payment*	Up to $100 after $20 *co-payment*
Lenticular Lenses	Covered in full after $20 *co-payment*	Up to $125 after $20 *co-payment*
Frames	Frame of your choice, up to $200 after $20 *co-payment*; Plus 20% off any out-of-pocket cost for the frame	Up to $70 after $20 *co-payment*
Polycarbonate Lenses (for children up to age 18)	Covered in full	Up to the lenses allowance
Eyewear: Contact Lenses	***(once every 12 months instead of lenses and frames)***	
Medically Necessary (prescribed for medical conditions where glasses cannot correct vision)	Covered in full	Up to $210
Elective	Up to $200 (may include evaluation and fitting)	Up to $105
Low Vision Benefit	***(required prior approval)***	
Supplemental Testing	Covered in full	Up to $125
Supplemental Aids *Coinsurance*	Plan pays 75% of the cost	Plan pays 75% of the cost
Maximum Allowable	$1,000 every 2 years	$1,000 every 2 years
Diabetic Eyecare Program	***(VSP provider only)***	
Ophthalmological Services and Office Visits	Covered in full after $20 *co-payment*	N/A
Gonioscopy	Covered in full once every 12 months	N/A
Extended Ophthalmoscopy	Covered in full once every 12 months	N/A
Fundus Photography	Covered in full once every 12 months	N/A

**Note: One material co-payment for lenses/frames or the combination of both. Scratch coating is covered on all lenses.*

HOW THE PLAN WORKS

The Vision Plan provides you and each of your covered dependents with an eye exam and prescription lenses and frames once every 12 months. You can use a doctor from the VSP provider network for

your exam and glasses or a doctor and/or optician outside the network. The eye exam and eyewear are subject to separate *co-payments*. After the *copayments* are made, the Plan pays the amount shown in the chart for in-network or out-of-network charges. Contact lenses are not subject to *co-payments*.

In-Network Services

When you use a VSP network provider, you will not have any out-of-pocket expenses other than the applicable *copayments* for the following services:

- A comprehensive eye exam; and
  - Single vision, lined bifocal or lined trifocal lenses;
  - Frame within the retail allowance, or
  - Contact lenses within the allowance (*co-payment* is not applicable).

There will be additional out-of-pocket costs if you select optional items such as oversize lenses, no-line multi-focal lenses (progressives), AR coating, tints or a frame that exceeds the Plan's allowance. For a complete list of optional services, visit www.vsp.com or call VSP at 1-800-877-7195.

When you need vision care, contact a VSP network provider to make an appointment. To find a VSP network provider close to you, visit www.vsp.com or call 1-800-877-7195. Identify yourself as a VSP member and provide your identification number. The doctor will confirm your eligibility and obtain authorization for the services and supplies. VSP will pay the doctor directly for covered services and materials. You pay the doctor your *co-payment* and for any optional services.

Out-of-Network Services

You can receive services and eyewear from any licensed optometrist, ophthalmologist or dispensing optician. When you use a non-VSP provider, the Plan will pay up to the amount shown in the Schedule of Benefits chart above less any *co-payment*. You pay the charges in full and then submit a claim to VSP for reimbursement.

COVERED VISION SERVICES

- **Eye Examination:** Complete initial vision analysis once every 12 months, which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.
- **Lenses and Frames:** Eyewear once every 12 months, which includes professional services as are necessary such as:
  - Prescribing and ordering proper lenses;
  - Assisting in the selection of frames;
  - Verifying the accuracy of the finished lenses;
  - Proper fitting and adjustment of frames;
  - Subsequent adjustments to frames to maintain comfort and efficiency;
  - Progress or follow-up work as necessary.
- **Contact Lenses:** Contacts once every 12 months in lieu of all other lens and frame benefits. When contact lenses are obtained, you are not eligible for lenses or frames again for 12 months. Coverage includes *medically necessary* and elective contact lenses.

Discounts

When you go to a VSP network provider, you may receive the following:

- Polycarbonate lenses for dependent children covered in full.
- Up to 35-40% savings on cosmetic extras, such as anti-reflective coatings, tints and progressives.
- 30% discount off additional prescription glasses and sunglasses on the same day from the same VSP doctor who provided your eye exam. A 20% discounted is provided at any VSP within 12 months of the examination.
- 15% off cost of contact lens exam (fitting and evaluation).

However, note:

- Discounts do not apply to vision care from non-VSP providers.
- Discounts apply to complete pairs of glasses only.
- Discounts do not apply if prohibited by the manufacturer.
- Discounts do not apply to sundry items, such as contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

LASER VISION CORRECTION

A discount is available for laser surgery when obtained through VSP contracted doctors, surgeons and laser centers.
Discounts are available on the most common laser vision correction procedures, LASIK, custom LASIK and PRK. Call VSP at 1-888-354-4434 or go online at www.vsp.com to find a doctor that participates in this program.

LOW VISION BENEFIT

A low vision benefit is available if you have severe visual problems that are not correctable with regular lenses. This benefit is subject to prior approval by VSP's Optometric Consultants. Coverage includes professional services, as necessary, for severe visual problems not corrected with regular lenses, including:

- Supplementary testing, which includes evaluation, diagnosis and prescription of vision aids where

indicated; and

- Supplementary care and aids, which includes subsequent low vision therapy as *medically*

necessary or appropriate.

This benefit is subject to certain limitations; contact VSP at 1-888-354-4434 for more information. In addition, there is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ± .50 diopter power); or two pair of glasses in lieu of bifocals.

- Replacement of lenses and frames furnished under this Plan that are lost or broken except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Corrective vision treatment of an *experimental nature* such as, but not limited to, RK and PRK Surgery.

DIABETIC EYECARE PROGRAM

The Diabetic Eyecare Program (DEP) is available if you have been diagnosed with Type 1 diabetes and have specific ophthalmological conditions. You must use a VSP network provider; however, no referrals or authorizations are required for services provided under the DEP.

This program does not cover medical treatment for any diabetic or other medical condition.

Covered services include:

- Ophthalmological services;
- Office visits;
- *Gonioscopy*;
- *Extended ophthalmoscopy*; and
- *Fundus photography*.

These services are subject to change. In addition, service and/or diagnosis limitations apply, or certain procedures require special handling. VSP Network Doctors must consult the VSP Provider Reference Manual for details before providing services.

The DEP covers diabetic eyecare evaluation services only. There is no coverage provided under the Plan for:

- Costs associated with securing frames, lenses or any other materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical procedures, including Laser or any other form of refractive surgery, and any pre- or post-operative services.
- Pathological treatment of any type for any condition.
- Any eye examination required by an employer as a condition of employment.
- Insulin or any medications or supplies of any type.
- Services and/or materials not included in this Rider as covered Plan Benefits.

Limitations and Exclusions

LIMITATIONS

The Plan is designed to cover visual needs rather than cosmetic materials. When you select any of the following extras, the Plan will pay the basic cost of the allowed lenses and you are responsible for the additional costs for the options:

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere).
- Certain limitations on low vision care.

Some expenses are not covered by Genesis Alkali's Vision Plan. Expenses not covered by the Vision Plan include:

- Orthoptics, vision training or any associated supplemental testing.
- Plano lenses (less than a ± .50 diopter power).
- Two pairs of glasses in lieu of bifocals.
- Replacement of lost or broken lenses or frames, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Any eye examination or any corrective eyewear required by an employer as a condition of employment.
- Corrective vision treatment of an *experimental nature*, such as, but not limited to, RK and PRK surgery.

Filing a Claim

There are no claim forms to file if you use a VSP network doctor.

For out-of-network reimbursement, pay the entire bill when you receive services. Complete and submit an Out-of-Network Reimbursement form with your itemized receipts to the *Claims Administrator* at the address on the form. You can download a form online at www.vsp.com or by contacting VSP Customer Service at 1-800-877-7195.

CLAIM SUBMISSION DEADLINES

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

TYPES OF CLAIMS

- **Urgent Care**: A claim for care or treatment where the period for making a non-urgent care determination could seriously jeopardize your life, health or ability to regain maximum function or that, in the opinion of your doctor, would subject you to severe pain that cannot be adequately managed without care or treatment.

- **Pre-Service Claim**: A claim for a benefit where the Plan requires you to request authorization before treatment.

- **Post-Service Claim**: Any claim that is not an urgent care or pre-service claim.

If an ongoing course of treatment was previously approved for a specific period or number of treatments and your request to extend the number of treatments is an urgent care claim, your request will be decided in 24 hours if such request is made more than 24 hours prior to the end of the approved treatment. If your request is not made more than 24 hours prior to the end of your approved treatment, your request will be treated as an urgent care claim and the time limits in the chart above will apply.

INITIAL REVIEW AND DECISION

When a claim is filed properly, the *Claims Administrator* reviews the claim and notifies you of the determination within specified time limits. These time limits vary depending on the type of claim, as follows:

Time Limits	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
If you do not follow the proper procedure for filing a claim you will be notified:	Within 24 hours after receiving the improper claim	Within 5 days after receiving the improper claim	N/A
If additional information is needed, you will be notified:	Within 24 hours after receiving the claim	Within 15 days after receiving the claim	Within 15 days after receiving the claim
If additional information is needed to process your claim, you will have up to:	48 hours after receiving notice to provide the information	45 days after receiving notice to provide the information	45 days after receiving notice to provide the information

Notice of the initial decision will be provided:	• Within 72 hours after receiving a properly completed claim; or • Within 48 hours after the earlier of receipt of additional information or your deadline to provide additional information	• Within 15 days after receiving a properly completed claim; or • Within 15 days after the earlier of receipt of additional information or your deadline to provide additional information If an extension is necessary due to matters beyond the Plan's control, you will be notified within the initial 15day period that up to an additional 15 days is necessary (30-day maximum).	• Within 30 days after receiving a properly completed claim; or • Within 15 days after the earlier of receipt of additional information or your deadline to provide additional information If an extension is necessary due to matters beyond the Plan's control, you will be notified within the initial 30day period that up to an additional 15 days is necessary (45 day maximum).

NOTICE OF DETERMINATION

You will generally receive written notice of a claim decision within the time limits described in the chart above. For an urgent care claim, you may receive oral, written or electronic notice. Oral notice will be followed up with written or electronic notice within three days.

IF YOUR CLAIM IS DENIED

If your claim is denied (in whole or in part), you will receive a notice that includes:

- The specific reason or reasons for the denial;
- Reference to the specific Plan or Plan Document provision on which the determination is based;
- A description of any additional material or information that is needed to complete the claim and an explanation why this material or information is needed;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim;
- A description of the Plan's review procedures and the time limits applicable to these procedures (If your claim involves a claim for urgent care, the notice will include a description of the expedited review process applicable to this claim.)
- 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 an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, a copy of the internal rule, guideline, protocol or other similar criterion (or a statement that the denial was based on this authority and that a copy of the authority will be provided free of charge upon request); and
- If your claim is denied based on *medical necessity* or experimental treatment or a similar exclusion or limit, the notice must include an explanation of the scientific or clinical judgment for the determination or in lieu thereof, a statement that such explanation will be provided to you free of charge upon request. The notice must apply the terms of the plan to your medical circumstances.

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

The time limits for appeal of a denial of your claim for benefits are as follows:

Time Limit for:	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
You to file a first appeal	180 days after receiving the claim denial notice	180 days after receiving the claim denial notice	180 days after receiving the claim denial notice
The Plan to notify you of the first appeal decision	72 hours after receiving the appeal	15 days after receiving the appeal	30 days after receiving the appeal
You to file a second appeal	180 days after receiving the first appeal denial notice	180 days after receiving the first appeal denial notice	180 days after receiving the first appeal denial notice
The Plan to notify you of the second appeal decisions	72 hours after receiving the appeal	15 days after receiving the appeal	30 days after receiving the appeal

FIRST APPEAL

If you receive a claim denial notice, you or your authorized representative may request, in writing, a full and fair review of the initial claim decision. To request a review, within 180 days after receiving the notice, send your written request for an appeal involving:

- **Eligibility** to:
  Genesis Alkali, LLC Human Resources
  Genesis Alkali, LLC
  1735 Market Street
  Philadelphia, PA 19103

- **Vision claims** to:
  VSP
  Member Appeals
  3333 Quality Drive
  Rancho Cordova, CA 95670
  1-800-877-7195

You will have the opportunity to submit written comments, documents, records and other information relating to your claim.

The *Plan Administrator* will provide access to, and copies of, documents, records and other information relevant to your claim for benefits (other than legally or medically privileged documents) free of charge.

Your appeal should include your name and identification number, the dates of medical service that are the basis of the claim, your provider's claim number and an explanation why you believe the claim should be paid. You may submit this information by phone or facsimile for urgent care claims.

The Claims Administrator serves as the final review committee and, in its sole discretion, has the authority to interpret Plan provisions as well as facts and other information related to claims and appeals.

When your appeal is received, it will be reviewed and a decision will be made based on comments, documents, records and other information you have submitted, without regard to whether this

information was submitted or considered in the initial benefit determination. Your appeal will be reviewed in accordance with the time limits above.

This review will not afford deference to the initial denial and will be performed by the appropriate Plan fiduciary who is neither the individual who made the initial claim denial nor the subordinate of that individual.

If your claim is denied based in whole or in part on a medical judgment – including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not *medically necessary* or appropriate – the fiduciary reviewing the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The *Claims Administrator* will identify medical or vocational experts whose advice was obtained by the Plan in connection with the denial, without regard to whether the advice was relied on in making the benefit determination.

The health care professional consulted by the fiduciary reviewing the claim will be an individual who is neither an individual who was consulted in connection with the denial of the appeal nor the subordinate of such individual.

If your claim involves a claim for urgent care, the appeal request may be made orally or in writing and all necessary information may be transmitted by telephone, facsimile or other similarly expeditious methods.

NOTICE OF DECISION ON FIRST APPEAL

If your first appeal is denied (in whole or in part), you will receive a notice that includes:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provision on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim;
- 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 ERISA after you have exhausted all of your appeals under the Plan;
- If an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, a copy of the internal rule, guideline, protocol or other similar criterion (or a statement that the denial was based on this authority and that a copy of the authority will be provided free of charge upon request); and
- If your claim is denied based on *medical necessity*, experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment (or a statement that the explanation will be provided free of charge upon request). The notice must apply the terms of the Plan to your medical circumstances.

SECOND APPEAL

If, on the first appeal, the *Claims Administrator* upholds the denial of your claim, you may file a second appeal, in writing, within 180 days after being notified of the denial of your first appeal.

Your second appeal should include any additional information that you have not previously submitted, as well as an explanation supporting your position. The second appeal will be completed within the time provided in the chart above. Send your second appeal to:

Genesis Alkali, LLC Human Resources
Genesis Alkali, LLC
1735 Market Street
Philadelphia, PA 19103

The second appeal will follow the same procedures as the first appeal. If the second appeal is denied, you will receive a notice that includes all of the required information included in the first appeal notice. If your second appeal is denied, you have the right to take legal action against the Plan.

Coordination of Benefits (COB)

WHEN THERE IS ANOTHER VISION 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 dependent children 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

Bob 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 $300 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 $200.

— The Plan, according to its rules, determines that it would have paid $250 if this Plan was primary.

— Since the spouse's plan is primary, the Plan pays $50, which is the difference between its regular benefits ($250) and the amount the spouse's plan pays ($200), or $250 - $200.

In this case, the spouse receives $250 from the two plans combined. If her employer's plan had paid $250 or more, the Plan would not make any payment.

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 Vision 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:
Vision Service Plan
333 Quality Drive
Rancho Cordova, CA 95670

EMPLOYER IDENTIFICATION NUMBER

47-2173866

PLAN NUMBER

503

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 vision coverage.

PLAN FUNDING

Vision benefits are fully insured and provided by an insurance company in accordance with the provisions of a group insurance contract with:

Vision Service Plan
333 Quality Drive
Rancho Cordova, CA 95670
Group Number: 1206224

Insurance premiums are paid from Genesis Alkali general assets and employee payroll deductions.

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 *Plan Administrator* has discretionary authority over all appeals of denied claims. All appeal determinations made by the *Plan 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 SAME-SEX 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 (COBRA) OF 1985, AS AMENDED

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 (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, 75% *coinsurance* means a plan would pay 75% of covered expenses and you would pay the remaining 25% of covered expenses.

CO-PAYMENT

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

EMERGENCY CONDITION

A condition, with sudden onset and acute symptoms, that requires you to obtain immediate medical care, or an unforeseen occurrence calling for immediate, non-medical action.

EXPERIMENTAL NATURE

Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.

EXTENDED OPHTHALMOSCOPY

A method of examining the posterior of the eye, including a true drawing of the retina accompanied by an interpretation and plan.

FUNDUS PHOTOGRAPHY

Taking photos of the inside of the eye that show the optic nerve and retinal vessels.

GONIOSCOPY

Use of a special contact lens to look at the eye's acqueous drainage area.

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*.

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.

WORKERS' COMPENSATION

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