GENESIS ENERGY HEALTH & WELFARE BENEFITS PLAN

Wrap Summary Plan Description

This Wrap Summary Plan Description ("Wrap SPD") summarizes the terms of the Genesis Energy Health and Welfare Benefits Plan in effect as of January 1, 2022. Please keep this document in a safe place and share it with the members of your family covered under the Plan.

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INTRODUCTION

Purpose of the SPD

This Summary Plan Description ("SPD") is designed to provide you with a summary of the underlying policies and programs provided for the Genesis Energy Health and Welfare Benefits Plan (the "Plan"), which is sponsored and maintained by Genesis Alkal, LLC or Genesis Energy, LLC (the "Parent Company"), collectively referred to as "the Company". The information contained in the SPD is effective as of January 1, 2022.

How to Use this Document

Your SPD consists of this document, and, in some cases, an additional benefit summary that is incorporated by reference into this SPD. For example, the SPD for your medical benefits consists of this document plus the summary of benefits coverage (SBC) prepared by Blue Cross Blue Shield of Texas for your applicable coverage option. In the event of any inconsistency between this document and the separate benefit summary, the insurance policy or plan document will control.

This SPD replaces and supersedes any previous SPDs regarding the Plan. However, this SPD is not the document that governs the Plan. The Genesis Energy Health and Welfare Benefits Plan Document (Plan Document) governs this Plan. If there is a conflict between the Plan Document and this SPD, the Plan Document will govern.

Genesis Energy, LLC intends to continue the Plan indefinitely. However, Genesis Energy, LLC reserves the right to terminate or modify the Plan, including employee eligibility to participate, at any time. 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.

Should you have any questions regarding this document or the information within, contact your Benefits Department at benefitsconnections@genlp.com or 1-877-241-9624.

Eligibility

This section describes who can be covered, how to enroll, who pays for what, when coverage begins and ends, and when coverage can be continued in the Company's health and welfare benefit plans and programs.

Overview

You may enroll for benefits when you are first hired if you are considered a full-time employee of the Company and again for certain benefits each year during Annual Enrollment or if you have a family life change. Some benefits are provided to you automatically at no cost; others you can choose to participate in.

Your Eligibility

You are eligible to participate in the benefit plans described in this summary on your date of hire as an employee. "You" or "Your", within the context of this SPD, means an employee:

- employed on a regular basis by the Company in the conduct of the Company's regular business,
- You are a non-union employee of the Company,
- regularly scheduled to work at least 30 hours per week, and
- classified by the Company, pursuant to its regular administrative practices or policies, and listed on the Company's payroll records as a common law employee.

The term "employee" shall exclude any other individual, including, but not limited to, any individual who is (i) a leased employee under Internal Revenue Code of 1986, as amended ("Internal Revenue Code") section 414 (n), (ii) a temporary or seasonal employee (i.e. intern or Trip Pilot) unless the temporary or season employee meets the requirements under the Affordable Care Act, or (iii) covered under a collective bargaining agreement which is the subject of good faith bargaining, unless the collective bargaining agreement provides for participation in the underlying benefit plan.

The term "employee" shall exclude any individual classified by the Company, in its sole discretion, in a designation which would exclude the person from being considered as an employee under the Company's customary worker classification procedures, regardless of whether such classification is in error.

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

Dependent Eligibility

Certain coverage is available to your eligible family members. Eligible family members include your spouse and your dependent children.

A spouse includes only your legal spouse as determined under applicable state law; provided, however, that such spouse resides in the United States. A spouse includes same-sex or opposite sex marriages.

Domestic partners are not considered spouses (whether same-sex or opposite sex) in terms of eligibility for coverage unless provided you are considered spouses by legal affidavit issued by state or local jurisdiction - either may have specific requirements for a domestic partnership.

If you and your spouse and/or dependent child both work for the Company:

- You can each be covered separately as employee-only coverage.
- One of you may cover the other as a dependent rather than as an employee, but not both.
- Only one of you may cover your children for purposes of the medical, dental, vision, FSA plan(s) and/or life insurance plan(s).

Only one employee may cover an eligible dependent. The plan prohibits the employee or dependent child from having double coverage under the same Plan.

Coverage for eligible dependent children differ by plan, as shown on the section below:

Medical, Dental, Vision, and Flexible Spending Account Plans

Any child of yours who is:

- Less than 26 years old;
- 26 years or older, primarily supported by you, and incapable of self-sustaining employment because of physical or mental handicap which can be expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months; or
- Subject to a valid Qualified Medical Child Support Order (QMCSO).

Proof of a child's mental or physical handicap and resulting dependence must be submitted to the claim administrator or the Company within 31 days after the date your child no longer qualifies as an eligible dependent, as described above. During the next two years, the claim administrator and/or the Company may, from time to time, require proof of your child's continuing condition. After that, the claim administrator or the Company may require proof no more than once a year;

A child includes:

- a biological child,
- a legally adopted child,
- a foster child, which means those placed with you by an authorized placement agency or by judgement decree or other order of any court of jurisdiction,
- a stepchild, or

A "child" includes an unmarried grandchild who meets all of the conditions:

- is your dependent for income tax purposes under Section 152 of the Internal Revenue Code at the time of enrollment in the benefit plan; and
- is subject to being under your legal guardianship under applicable state law, court order or decree.

Any child of divorced parents to whom Internal Revenue Code Section 152(e) applies shall be treated as a dependent of both parents.

Notwithstanding anything in this section to the contrary, a "child" only includes those children for whom benefits can be provided on a tax-free basis under Section 105(b) of the Internal Revenue Code and corresponding guidance. You may be asked to provide proof of your dependent's status from time to time.

If both spouses are both eligible to participate in the Genesis benefit plans, their children may be considered dependents of either one or the other, but not both.

Life and Accidental Death & Dismemberment (AD&D)

- Any unmarried child of yours from birth to 26 years old
- A child includes your legally adopted child, a child placed with you for adoption prior to legal adoption, a stepchild or foster child who depends on you for support and maintenance.

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.

Affordable Care Act

Under the Affordable Care Act (ACA), part-time employees will be eligible to enroll in the **medical plan only** if they meet the full-time eligibility requirements under the ACA.

Terms to determine full-time eligibility under the ACA:

- **Standard Measurement Period**: 12 month calendar period, November 1 through October 31, used when evaluating time worked to determine full-time eligibility status for part-time workers
- **Initial Measurement Period**: Calendar period up to 12 months, determined by a new employee's date of hire, used when evaluating time worked to determine full-time eligibility status for part-time workers
- **Standard Stability Period**: 12 consecutive calendar months, January through December, during which a part-time employee who has met the hours of service requirement under the ACA will be classified as a full-time employee for purposes of eligibility and enrollment in the medical plan
- **Initial Stability Period**: for an employee not previously employed for a Standard Stability Period, The initial stability period is usually the same length as the initial measurement period, but it can't be less than six months, during which a part-time employee who has met the hours of service requirement under the ACA to be classified as a full- time employee for purposes of eligibility and enrollment in the medical plan
- **Administrative Period**: the time period used to evaluate hours worked and determine full-time eligibility for part-time workers and allow for enrollment in medical benefits during this time period; the administrative period is the time between the end of the standard measurement period and the start of the standard stability period

For ongoing employees who have worked for Genesis for one full Standard Measurement Period, full-time eligibility is determined by whether the employee worked an average of at least 30 hours of service per week by looking back at a defined period of 12 consecutive calendar months, November through October (the Standard Measurement period). If an employee has worked full-time during a Standard Measurement Period, then the employee is treated as full-time during the Standard Stability Period so long as he or she remains employed during that period and regardless of the hours actually worked.

Newly hired employees will be evaluated based on a period of up to 12 consecutive calendar months (Initial Measurement Period). Full-time eligibility is determined if the employee worked an average of at least 130 hours of service per month. If an employee is determined to have met the hours of service

requirements during the Initial Measurement Period, then the employee is treated as full-time eligible during the Initial Stability Period so long as he remains employed during that period and regardless of the hours actually worked during the Initial Stability Period.

Hours of service include paid time off due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

The Administrative Period is November through December. To prevent the administrative period from creating a potential gap in coverage, it overlaps with the prior stability period, so ongoing full-time employees will continue to be offered coverage during the administrative period. For example, an employee entitled to coverage for a stability period that is calendar year 2022 will be covered during any administrative period in 2022.

Employees who qualify for coverage under the ACA provisions are eligible to participate in the medical plan for the Standard/Initial Stability Period following the Standard/Initial Measurement Period in which they meet the hours worked criteria. Hours worked will be re-evaluated annually during the Administrative Period based on the prior Standard Measurement Period to determine eligibility for the following Standard Stability Period.

If an employee is determined to be full-time eligible under the ACA, including eligible dependent children and spouses.

Enrollment

As a New Employee

You must enroll in or decline coverage within 31 days of your date of hire, where your date of hire is day one (1). You also choose whether to cover your dependents (this includes spouse and child(ren).

Enrollment resources are available online at www.genesisenergy.com/humanresource including a benefits guide and video. Review the information carefully, complete your enrollment online through Dayfoce within 31 days of your date of hire. The coverage options you choose remain in effect until the end of the plan year (December 31) unless you make a change because of qualifying life event or status change during the year.

If You Do Not Enroll When First Eligible

If you do not enroll by your deadline as a new employee, you will have only the following the Company paid coverages:

- Basic employee Life
- Basic employee Accidental Death & Dismemberment (AD&D)
- Business travel accident
- Short-term disability (STD) (excluding Genesis Marine vessel workers)
- Long-term disability (LTD) coverage (excluding Alkali Non-union employees)
- Employee Assistance Program (EAP)

You will not have coverage for medical, dental, vision, optional life, optional AD&D, flexible spending accounts (FSA). Genesis Marine vessel workers additionally will not have short-term disability and

Genesis Alkali Non-union employees will not have Long-term disability. You will not be able to enroll or make changes to coverage in the medical, dental, vision, life, disability and/or flexible spending accounts until the next annual enrollment period, unless you have a qualifying life event.

If you did not elect/change coverage for medical, dental or vision for yourself and/or your dependents as a new employee during your initial enrollment period and decide to enroll later, you will be required to provide proof of your qualifying life event within 31 days of the date of the event and complete any dependent verification that is required within that same timeframe. See the Qualifying Life Event section for more information.

If you did not elect/change coverage in the supplemental life or disability coverage for yourself and/or your dependents as a new employee during your initial enrollment period and decide to enroll later, the insurance company may require that you complete an evidence of insurability (EOI) to be approved before your coverage goes into effect.

Annual Enrollment

Generally, each fall, you may elect coverage in medical, dental, vision and flexible spending accounts for the following plan year (January 1 – December 31). Before the enrollment period begins, you will receive information about any changes to plan provisions, the coverage options available for the coming year and your costs.

Generally, the elections you make during annual enrollment take effect the following January 1 and remain in effect until December 31, unless you make a change due to a qualifying life event.

ID Cards

You will receive identification cards at your home address if you enroll in a medical and/or dental plan. You will receive a debit card at your home address if you enroll in a Flexible Spending Account (FSA) or Health Savings Account (HSA). Many of our insurance carriers also have mobile apps with digital IDs for your convenience.

Naming a Beneficiary

A beneficiary is someone who receives benefits in the event of your death. You need to designate beneficiaries for the following coverages:

- Basic employee Life
- Optional employee Life
- Basic employee AD&D
- Optional employee AD&D

To designate a beneficiary, complete and submit your beneficiary designation form to the Benefits Department. If you name more than one beneficiary, you also must designate what portion of the entire benefit should be paid to each. If you fail to name a percentage, the benefit will be paid in equal shares to each surviving beneficiary.

Beneficiary designation is completed in Dayforce under Forms.

You are automatically the beneficiary for your dependent's life and AD&D benefits. If you choose to assign benefits, you should contact your legal counsel for guidance.

Changing Your Beneficiary

Because family situations can change, you should review your beneficiary designations every year. You may change your beneficiary at any time by submitting a new beneficiary designation form in Dayforce. The new designation takes effect on the date you submit the change.

If You Do Not Name a Beneficiary

If you have not named a beneficiary (or if your beneficiary dies before you), the insurance company may determine who your benefits will be paid to in the instance of your death, in accordance with the hierarchy determined by the insurance company.

For More Information

Consult the relevant insurance policies for complete information about naming a beneficiary.

Cost

The following chart shows the different types of coverage available, who pays for the coverage, and how you pay your share of your coverage (pre-tax vs post-tax).

Coverage	Who Pays	Paid Pre-tax vs Post- tax
Medical/Rx Plan	Genesis & You	Pre-Tax
Dental Plan	Genesis & You	Pre-Tax
Flexible Spending Accounts	You	Pre-Tax
Vision Service Plan - Energy	You	Pre-Tax
Basic Employee Life and AD&D Insurance	Genesis	N/A
Optional Life and AD&D Insurance (Employee and/or Dependents)	You	Post-Tax
Short-Term Disability Plan	Genesis	N/A
Short-Term Disability (Genesis Marine Vessel Workers)	You	Post-Tax
Long-Term Disability Plan	Genesis	N/A
Long-Term Disability Plan (Alkali Non-union)	You	Post-Tax
Business Travel Accident Insurance*	Genesis	N/A
Employee Assistance Program (EAP)*	Genesis	N/A
Legal Plan	You	Post-Tax
Identity Theft Program	You	Post-Tax
Health Savings Account (HSA)	You	Pre-Tax

*These benefits will be treated by your employer as group health plan benefits only to the extent the plan administrator determines such benefits are subject to the special enrollment requirements of the Internal Revenue Code, including, but not limited to, those under HIPAA (as defined in this summary).

You and the Company share in the cost of your coverage. You pay for your medical, vision, dental coverage, flexible spending account contributions, and Health savings account contributions on a pre-tax basis. This means your contributions are deducted from your pay before federal income tax, Social

Security tax and, in most cases, state or local taxes are withheld. This lowers your taxable income, so your overall tax bill is less.

It is important to remember that your Social Security benefit will be based on a slightly lower earnings amount. However, any reductions in your Social Security benefit may be offset in part by the tax saving you receive now by paying for your benefits with pre-tax dollars. Benefits based on your compensation level, such as life insurance, are not affected because they are based on your full pay before any deductions are made.

You pay for any vision (Genesis Marine only), supplemental life and AD&D, and short-term disability benefits with after-tax dollars.

You will be notified of contribution amounts when you first enroll, and again each year during the annual enrollment period.

Failure to make payment for your plan coverage will result in termination of benefits, and you will forfeit your right to COBRA. Should you miss any payments due to disability, leave of absence, administration absence, or otherwise, you are responsible for continuing to make payments for coverage. Genesis reserves the right to collect any missed payments in arrears in a lump sum deduction upon return from work.

Imputed Income

If your basic life insurance coverage exceeds $50,000, you are taxed on the value of the coverage that is over the $50,000 amount. This amount is added to your W-2 form for tax purposes and reflected on your paycheck as Group Term Life or GTL.

Qualifying Life Event

Changing Your Coverage Mid-Year

Generally, your pre-tax benefit elections (medical, dental, vision, and/or flexible spending accounts) are in effect throughout the plan year. However, if you have a qualifying life event, you may enroll in certain coverages, change certain coverages, and add or drop dependents. Any change you make to your benefits must be because of and consistent with your event, as allowed under applicable laws. A status change includes:

- An event that changes your legal marital status, including marriage, legal separation, annulment, divorce, death of spouse.
- An event that changes your number of dependents, including birth, death, adoption or placement for adoption.
- An event that changes your employment status, or your dependent's employment status, such as termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, switching between part-time and full-time status, or having a reduction or increase in hours of employment.

An event that results in a change in your dependent's eligibility for benefits due to age, disability status, or similar circumstance.

- An event that results in a change in your, or your dependent's, residence.

Election changes may also be permitted in other circumstances to the extent provided by law, including, but not limited to, section 125 of the Internal Revenue Code and the corresponding Treasury Regulations.

If you have a status change and want to change your coverage, you must complete the Life Event Declaration under Forms in Dayforce. The Life Event Declaration, any supporting documents required to substantiate the claim and verifying your dependents, **must be completed within 31** days of the date of the event (i.e. baby's date of birth, wedding date, divorcee decree finalized).

If you do not complete all parts within 31 days of the event where day one is the date of the event, you must wait until the next annual enrollment period to initiate the change, or until you experience another qualifying life event.

All newborns born to a covered employee or spouse are covered under the medical plan, must be enrolled by you within 31 days. Claims will be initially covered for the first 31 days but failure to enroll the newborn permanently on the plan will result in coverage termination back to the date of birth.

Qualifying Life Event	Permitted Changes
Marriage	• Enroll yourself • Change Plan option • Enroll new spouse • Add or drop dependent(s) coverage related to the new spouse.
Divorce, legal separation, or death of a spouse	• Enroll yourself if you lose coverage under former spouse's plan • Change Plan option • Drop spouse • Add or drop dependent(s) coverage related to the spouse (i.e. step children).
Birth, adoption (or child placed for adoption) or foster child	• Enroll yourself • Change Plan option • Add dependent(s) to coverage
Death of a dependent child	• Change Plan option • Drop dependent from coverage
Lose eligibility for benefits due to a change in your, your spouse's employment status	• Enroll yourself • Add dependent(s) to coverage who also lost coverage
Gain eligibility for benefits due to a change in spouse's employment status	• Drop coverage • Drop dependent(s) from coverage who gain new coverage

Loss of a dependent's eligibility due to age	• Drop only dependent from coverage that reaches age limit
Change in eligibility due to termination of your, your spouse's, employer contributions towards coverage or a significant change in cost of coverage (+/- 200% from prior amount)	• Enroll yourself • Add dependent(s) to coverage
Change in eligibility for benefits due to loss of CHIP or Medicaid coverage (timeline to make changes extends from 31 days to 60 days under HIPAA.)	• Enroll yourself • Add dependent(s) to coverage who were impacted
Change in eligibility for benefits due to becoming eligible or ineligible for employee contribution subsidies from CHIP or Medicaid (timeline to make changes extends from 31 days to 60 days under HIPAA.)	• Enroll yourself • Change Plan option • Drop coverage • Add or drop dependent(s) coverage who were impacted
Moving out of network service area to a location where you current plan/carrier doesn't have providers available	• Change Plan option

Consistency Rule for Qualifying Life Events

You may make a mid-year change in your benefit elections because of a status change occurring during a plan year only if the election is on account of the qualifying event, the new election corresponds with the event, and the status change affects eligibility for those coverage under the applicable benefit program ("consistency rule"). The Benefits Department will determine whether your status change and subsequent election satisfy the consistency rule in accordance with the Internal Revenue Code and other guidance issued by the Internal Revenue Service. Only those individuals affected by the change are eligible for a new election. For example, the birth of a child does not permit you to drop coverage for your spouse.

Judgment, Decree or Order

You may change your health benefit election during the year if the change is on account of, and consistent with, a judgment, decree or order pursuant to a divorce, legal separation, annulment or change in legal custody requiring health coverage for your child. You may cancel your election for coverage for the child only if health coverage is actually provided to the child by an individual as required by the judgment, decree or order. You must still take action to request changes to your benefits within 31 days of the event or you risk not being allowed to make changes. If you fail to make changes timely, you will forfeit a refund of any overpaid premiums.

Entitlement to Medicare or Medicaid

You may change your health benefit election to cancel, reduce or begin coverage if you become entitled to, or lose, coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), or Title XXI of the Social Security Act (CHIP) other than coverage

consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). The same rule applies to dependents.

To the extent required by the Employee Retirement Income Security Act of 1974, as amended (ERISA), you may have a status change/special enrollment right if you or your eligible dependent are eligible but not enrolled for coverage under the plan and 1) lose Medicaid or CHIP coverage as a result of loss of eligibility under those programs, or 2) become eligible for assistance under Medicaid or CHIP. Loss of eligibility does not include a loss of coverage for cause (such as a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

You or your dependent must request special enrollment and enroll no later than sixty (60) days from the date of termination of Medicaid or CHIP coverage or sixty (60) days from the date the individual is determined to be eligible for contribution assistance by the state of residence. The effective date of coverage as a result of this type of special enrollment shall be the first day of the calendar month following the plan administrator's receipt of the completed enrollment forms.

Cost or Coverage Changes

You may be allowed to change your benefit option election due to the following cost or coverage changes:

- Cost Change: If the cost under any of your benefit elections increases or decreases, your paycheck deductions will automatically be changed to correspond to the cost change if the plan administrator determines that such an election change is permitted by the applicable benefit option and the law.
- Significant Cost Decrease: If the cost for a benefit option significantly decreases, the plan administrator may allow all eligible employees, including employees who have elected another benefit option and those who have not previously participated in the applicable benefit program, to elect the benefit option which had a significant decrease in cost.
- Significant Cost Increase: If the cost under any of your benefit elections significantly increases, the plan administrator may allow you to make a corresponding change to your benefit election, including revoking your election for the benefit option that significantly increased in cost. In such case, you may either elect to receive, on a prospective basis, a new benefit option providing similar coverage, or you may drop coverage if no other benefit option providing similar coverage is available.
- Reduction in Coverage: If your elected benefit option has a significant reduction in coverage, such as a significant increase in the deductible, the copayment, or the out-of-pocket maximum, the plan administrator may allow you to revoke that benefit election and elect, on a prospective basis, to receive coverage under another benefit option providing similar coverage.
- Loss of Coverage: If you have a loss of coverage under any of your benefit option elections, the plan administrator may allow you to revoke that benefit election and, in place of that benefit option, to elect another benefit option providing similar coverage or to drop coverage if no other benefit option providing similar coverage is available. A loss of coverage means a complete loss of coverage under the benefit option, including the elimination of a benefit option.

A ”significant” cost increase is when the premiums more are than double the prior amount. A “significant” cost decrease is when premiums are less than half of the prior amount.

A “significant” reduction in coverage is when your coverage, either the deductible, coinsurance, copayment, or out-of-pocket maximum more than doubles. A “significant increase in coverage is when your coverage, either the deductible, coinsurance, copayment or out-of-pocket maximum, is less than half of the prior amount.

In addition, the plan administrator may treat the following as a loss of coverage: 1) a substantial decrease in the health care providers available under a benefit option; 2) a reduction in the benefits for a specific type of health condition or treatment with respect to which you or your dependents are currently in a course of treatment; or 3) any other similar, fundamental loss of coverage.

- New or Improved Coverage: If a benefit option is added during a plan year, or if an existing benefit option is significantly improved, the plan administrator may allow eligible employees (whether or not they previously made an election under the applicable benefit program or have previously elected the benefit option) to revoke their existing benefit option and make an election, prospectively, for coverage under the new or improved benefit option.
- Another Employer’s Plan: A prospective election change under a benefit program that is made on account of a change made under the section 125 plan of another employer may be permitted if: 1) the other employer plan allows its participants to make election changes as provided by law; or 2) the other employer plan allows its participants to make elections for a period of coverage different from the period of coverage under the applicable benefit program.
- Government or Educational Plan: An election to add health coverage, prospectively, may be permitted if you or your dependent loses group health coverage sponsored by a governmental or educational institution, including the following: 1) a State’s Children’s Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; 2) a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; 3) a state health benefits risk pool; or 4) a foreign government group health plan.

Special Enrollment Rights Under HIPAA

You may change your health benefit election to cancel, reduce or begin coverage if you become entitled to, or lose, coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), or Title XXI of the Social Security Act (CHIP) other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). The same rule applies to dependents.

To the extent required by the Employee Retirement Income Security Act of 1974, as amended (ERISA), you may have a status change/special enrollment right if you or your eligible dependent are eligible but not enrolled for coverage under the plan and 1) lose Medicaid or CHIP coverage as a result of loss of eligibility under those programs, or 2) become eligible for assistance under Medicaid or CHIP. Loss of eligibility does not include a loss of coverage for cause (such as a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

You or your dependent must request special enrollment and enroll no later than sixty (60) days from the date of termination of Medicaid or CHIP coverage or sixty (60) days from the date the individual is determined to be eligible for contribution assistance by the state of residence. The effective date of

coverage as a result of this type of special enrollment shall be the first day of the calendar month following the plan administrator's receipt of the completed enrollment forms.

Changing your HSA Contributions

You may change your HSA contributions at any time during the year by making the change in Dayforce by clicking on Benefits than in the section "Health Savings Account Changes", click on Start Enrollment.

Highly Compensated Employees & Key Employees (And Modification of Coverage for All Employees)

Notwithstanding any provision in this summary or the benefit plans to the contrary, the Company or the plan administrator can modify, or reject elections or your (and your related dependents') right to receive benefits under any benefit plan including, to the extent permitted by law, suspend or reduce benefits for you:

- if you are a "highly compensated" or a "key employee" (or similar or related) as determined under various provisions of the Internal Revenue Code at such time and in such manner as it deems necessary or appropriate to ensure that one or more benefit plans comply with the nondiscrimination or other similar requirements under the Internal Revenue Code;
- if you fail to provide information requested by the plan administrator to comply with the information reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, 42 U.S.C. Section 1395y(b)(7)-(b)(8) or other applicable law; or
- if you fail to provide information for administrative or other benefit plan purposes, as requested by the plan administrator.

In addition, if you or your dependents continue to be covered under any benefit plan beyond what is permitted or any such individual engages in fraudulent or similar behavior with respect to a benefit plan, the plan administrator or the Company may terminate your and all your dependents' coverage under one or more benefit plans or take such other action as permitted by law as determined by the plan administrator or the Company.

When Your Coverage Ends

Your coverage for your benefit plan ends, subject to any additional limitations set forth in the terms of any insurance policy or this summary below, on the earliest of:

- the day your employment ends with the Company terminates or you retire from the Company;
- the last day of the month in which you terminate for health care coverage, which includes medical, dental and vision.
- the day employment ends with the Company for Life, AD&D, any optional coverage, legal plan, identity theft plan, flexible spending plan, and/or health savings account;
- the last day of the month in which you turn age 65 for retiree medical/dental and retiree Life/AD&D;
- the day you no longer qualify as an eligible employee of the Company;
- the day you cease to meet eligibility requirements for coverage under the benefit plan or the date

the plan administrator notifies you that you have failed to provide such forms, information or contributions as the plan administrator may require;

- anytime a written request to terminate coverage is submitted during an annual enrollment or due to a qualifying life event under the plan, effective as of the date specified by the plan administrator or its delegate
- the date the plan administrator or claim administrator determines whether you or your dependents have submitted a fraudulent claim and notifies you;
- the day you reach 36-months on approved Long-term Disability. If you fail to meet the definition of disability after your short-term disability benefits have been exhausted and do not return to work at the when you no longer qualify as disabled under LTD or reach 36-months on LTD, your employment with the Company will end and your health coverage under the Plan will end;
- You stop making the required contributions (benefit premiums);
- the day the Plan ends or terminates, or
- the day you die.

Notwithstanding the above provisions, when the Company is contractually obligated through a severance agreement or employment contract to provide coverage under a benefit plan for a designated time period after termination of employment with the Company, coverage under the benefit plan will be extended in accordance with such contract.

When Dependent Coverage Ends

Dependent coverage will cease, subject to any additional limitations set forth in the terms of any insurance policy or this summary below, for any dependent on the earliest of:

- the date the employee's coverage terminates;
- the date the benefit plan is terminates;
- the day in which the dependent coverage is discontinued under a benefit plan;
- the day in which you cease to be in a class eligible for dependent coverage;
- the day in which the employee no longer has any dependents;
- the day in which the dependent ceases to qualify as a dependent under the benefit plan or fails to provide such forms or information as the plan administrator may require, with the exception of medical which ends on the last day of the month in which the dependent child turns 26;
- in the case of a child for whom coverage is being continued due to mental or physical inability to earn his own living, the last day of the month during which the earliest of the following dates occurs:
    - cessation of such incapacity;
    - failure to furnish any required proof of the uninterrupted continuance of such incapacity or to submit to any required examination; or
    - cessation of support of the dependent by the employee.
- anytime a written request to terminate coverage is submitted during an annual open enrollment or due to a status change under the plan, effective as of the date specified by the plan administrator or its delegate; or

- the date the plan administrator or the claim administrator determines that the dependent has submitted a fraudulent claim and the dependent is notified of such fraudulent claim.

In addition, if you or your dependent continues to be covered under a benefit plan beyond what is permitted or engages in fraudulent or similar behavior with respect to the benefit plan, the plan administrator may terminate such dependent coverage under the benefit plan or take such other action as permitted by law as determined by the plan administrator.

If you or your dependent's coverage is terminated outside of the 31-day notification window, a refund of contributions will not be made for any period before the date of notification back to the event date. If benefits are paid prior to notification to the claim administrator by the plan administrator, refunds will be requested by the plan administrator.

When Coverage Continues

Under certain circumstances, you may be able to continue some of your benefits.

Generally, health care coverage continues during an approved leave of absence. A leave of absence may include worker's compensation, administrative leave, Family Medical Leave, short term disability and ADA leave if you continue making the required premium payments (i.e. contributions). 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 Inspira, Genesis third-party bill administrator 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. Coverage may end while on disability, as described in the When Your Coverage Ends section.

If your coverage is canceled due to non-payment while you are on an approved leave of absence, other than FMLA or USERRA leave (as described below), Genesis Alkali will not reinstate your coverage upon your return to work and you will not be eligible for COBRA. You must wait until the next annual enrollment period to re-enroll in coverage effective January 1 of the following year.

Family and Medical Leave

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 Benefits Department 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.

If you fail to return to work following FMLA leave, any medical plan and non-plan benefit contributions which the FMLA regulations permit the Company to recover are a debt owed by you to the Company. To the extent recovery is allowed, the Company may recover the costs through deduction from any sums due to you (*e.g.*, unpaid wages, vacation pay, etc.), provided such deductions do not otherwise violate applicable federal or state wage payment or other laws. The Company may recover such amounts if you fail to return to work after your FMLA leave entitlement has been exhausted or expires, unless the reason that you do not return is due to:

- The continuation, recurrence, or onset of a serious health condition (as defined in the FMLA Policy) which would entitle you to leave under the FMLA; or
- Other circumstances beyond your control as described in the FMLA regulations.

If you fail to return to work because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the Company from recovering its share of health benefit contribution payments made on your behalf during an unpaid FMLA leave, the Company may require a medical certification of your or the family members' serious health condition.

If the Company requests medical certification and you do not provide such certification in a timely manner (within 30 days), the Company may recover the health benefit contributions it paid during the period of FMLA leave. The amount that the Company may recover is limited to only the Company's share

of allowable contributions as would be calculated under applicable state or federal continuation coverage law ("COBRA") (excluding the additional COBRA 2% fee for administrative costs).

Military Leaves

If you leave the Company to perform uniformed service for a period generally not to exceed five years, special provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) may apply if you return to work at the Company. You must give advance notice of the leave, if possible, and satisfy certain other requirements, including timely return to employment when your military service ends.

You may continue coverage for yourself and your eligible family members in the medical dental, and vision plans for up to 24 months, so long as required contributions are paid. The USERRA period runs concurrently with COBRA. Please consult the plan administrator for more information on your USERRA rights.

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.

Employment Agreements

Any continuation coverage benefits for medical, dental, vision, and health care flexible spending accounts under an employment agreement between you and the Company will run concurrently with COBRA continuation coverage, unless specifically addressed in the employment agreement.

Continuation of Benefits – COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the medical, dental, vision, EAP, and health care FSA programs. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

COBRA continuation coverage can become available to you when you would otherwise lose your coverage. It can also become available to other members of your family who are covered under the medical, dental and health care FSA programs when they would otherwise lose their coverage.

Continuation coverage is the same coverage for the medical, dental, vision and health care spending account benefits that the plan provides to active employees. Each qualified beneficiary who elects continuation coverage will have the same rights under the medical, vision, dental and health care spending account programs as other participants and beneficiaries, including annual enrollment and special enrollment rights.

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 for the current month’s coverage.

At a Glance

The following chart shows who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues for medical, dental, and/or vision coverage. Special time periods apply to Health Care Spending Account coverage.

Coverage continues for:	If coverage ends because:	Who can elect *COBRA* coverage:
Up to 18 months	• Your employment 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

When Is COBRA Coverage Available?

Generally, COBRA is offered when coverage under the plan ends for medical, dental, vision, EAP, and health care FSA benefits. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the Company will notify the claim administrator of the qualifying event within 30 days of any of these events.

You Must Give Notice of Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Human Resources Department (or the persons or entities described in the Initial COBRA Notice ("COBRA administrator")) by completing and submitting the required form and documentation of the event within 60 days after the

qualifying event occurs. If this process is not followed, any spouse or dependent child who loses coverage may not be offered the option to elect continuation coverage.

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 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).
-

How Is COBRA Coverage Provided?

Once in receipt of the notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of spouses, and parents may elect COBRA continuation coverage on behalf of their children. You will be instructed how to elect and pay for COBRA continuation coverage in the materials you receive at that time. You should review and respond to this information promptly. Except as described below, you will have only one limited window following your qualifying event to elect COBRA. The deadline for electing coverage is 60 days from the later of the date that coverage would otherwise terminate or the date of the COBRA administrator's notification of COBRA rights.

Duration of COBRA Continuation Coverage

COBRA continuation is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA coverage can be extended.

- **Disability Extension of 18-Month Period of Continuation Coverage:** If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the Human Resources Department or the COBRA administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

The disability would have to have started at some time prior to the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension so long as one of the qualified beneficiaries qualifies. You must notify the Human Resources Department or COBRA administrator within 60 days after receiving notification from the Social Security Administration in order to receive the additional 11 months.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Human Resources Department or COBRA administrator of that fact within 30 days after the Social Security Administration's determination. COBRA continuation of benefits will end on the earlier of (1) the first day of the month that begins more than 30 days after the final determination under Title II or XVI of the Social Security Act that the disabled individual is no longer disabled, or (2) the date that is 29 months after COBRA coverage began.

- **Second Qualifying Event Extension of 18–Month Period of Continuation Coverage:** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan.

This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the plan as a dependent child but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Human Resources Department or COBRA administrator is notified on the second qualifying event within 60 days of the second qualifying event.

If, after the occurrence of a qualifying event, you, your spouse and/or your dependent children are allowed to continue health care coverage under the plan (whether or not contribution payment(s) are required) beyond the plan's termination of coverage provision for any reason other than to comply with

federal law, such continuation period(s) will run concurrently, except as expressly provided by an employment agreement between you and the Company.

When COBRA Continuation Coverage Ends

COBRA continuation coverage will be terminated before the maximum continuation period described above if one of the following events occurs:

- Any required contribution is not paid in full on time;
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both), after electing continuation coverage;
- The Company ceases to provide any group health plans for its employees; or
- Continuation coverage may also be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How Much Does COBRA Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an 11-month extension of coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

Special Rules for Health Care Flexible Spending Accounts

You or your dependents are also permitted to elect COBRA continuation coverage due to a qualifying event for your health care flexible spending account by continuing contributions on an after-tax basis. The COBRA rules described earlier in this section are similar, except, for example, that the maximum period for which you may continue after-tax contributions to your health care flexible spending account is the remainder of the plan year in which your qualifying event occurred.

Electing COBRA for health care flexible spending accounts gives you or your dependents the benefit of extending the time period for which claims for reimbursement may be incurred. Normally, to be eligible for reimbursement a claim must be incurred while you are covered under and contributing to the health care flexible spending account. If you have not incurred enough expenses at the time of your qualifying event to recover your contributions to the account, then you should consider electing COBRA in order to extend the coverage period long enough to incur claims that would allow for full reimbursement, but not past the end of the year. For this reason, COBRA is only available to you or your dependents if the amount you could be reimbursed exceeds the amount you would have to pay into the account on an after-tax basis.

COBRA Administrator

Inspira Financial administers the Company's COBRA coverage. If you have any questions, contact PayFlex Systems USA, Inc. by phone at (800) 359-3921 for assistance..

If you are a COBRA participant, please notify Inspira Financial if you or your spouse changes address, or if you have a change in family status which impacts your coverage.

MEDICAL

Your medical and prescription coverage is a key component to your health coverage. Medical coverage helps pay for treatment of an illness or injury. It protects you physically, and it protects you financially from the high cost of medical care. Prescription drugs are covered as part of your medical plan benefits.

Blue Cross Blue Shield of Texas is the claims administrator for medical, CVS Caremark is the pharmacy benefits manager, and the Company is the plan administrator of the group health plan. Together they determine the payments and types of benefits for you and your dependent's treatment of illness and injury. The Plan Administrator decides who is eligible to participate in the plan, not the claims administrator.

This section describes generally how the medical plan works. More detailed information about covered services and benefit provisions (deductible, coinsurance, out-of-pocket maximum and other cost-sharing features), can be found in the latest documents available online at www.genesisenergy.com/human-resources:

- Blue Cross Blue Shield of Texas Choice Plus PPO Benefit Booklet
- Blue Cross Blue Shield of Texas Choice Saver HSA Benefit Booklet
- Blue Cross Blue Shield of Texas Summary of Benefits & Coverage – Choice Saver HAS
- Blue Cross Blue Shield of Texas Summary of Benefits & Coverage – Choice Plus PPO

At a Glance

- The plan offers two medical coverage options: the Choice Plus PPO and the Choice Saver HSA.
- Both plans offer a network of health care providers who have agreed to offer services at a contracted rate.
- The Choice Saver HSA is a "high deductible health plan" that allows you to contribute to a health savings account (HSA).
- You may use the provider of your choice, but if you use an in-network provider you will receive higher benefits than if you choose an out-of-network provider.
- Your contributions for your coverage are deducted from your paycheck on a pre-tax basis.

Coverage Tiers

If you choose to participate in the medical plan, you select one of the following coverage tiers:

- Employee only
- Employee & spouse
- Employee & child(ren)
- Employee & family

What you pay for coverage

What you pay for medical coverage includes:

- Your payroll deductions
- Calendar year deductible;
- Copayments;
- Your coinsurance payments; and
- Non-covered medical services, procedures or prescription drugs.

Payroll Deductions

You and Genesis Alkali share in the cost of your medical coverage. Your payroll deductions are based on the option you select and the number of dependents you enroll. You have three coverage options:

Payroll deductions are determined annually. You can review current payroll deductions in Dayforce, in the Benefits Guide which is posted online at www.genesisenergy.com/human-resources or by contacting the Benefits Department. Rates for the upcoming plan year are available during annual enrollment.

Integration of In-Network and Out-of-Network Covered Expenses

Covered expenses applied to the out-of-network *deductible* do not apply to the in-network *deductible* and covered expenses applied to the in-network *deductible* do not apply to the out-of-network *deductible*.

The *out-of-pocket maximum* applies only applies out-of-network benefits. Covered expenses applied to the out-of-network *out-of-pocket maximum* only apply to the out-of network *out-of-pocket maximum* and covered expenses applied to the in-network *out-of-pocket maximum* only apply to the in-of-network *out-of-pocket maximum*.

The annual maximum benefit for in-network and out-of-network covered expenses accumulate separately.

Important Information About Out-of-Network Providers

Before you visit an out-of-network provider, you should be aware that the plan does not permit you to assign your benefits to third parties. Additionally, you are not permitted to name your provider as your "authorized representative". If your provider's bill exceeds the amount paid by the plan, you may be directly billed by the provider for the balance.

Authorized Representative

Is a person authorized to file claims or appeals on the participant's behalf. For this person to be considered an authorized representative, one of the following requirements much be met:

- The participants has given express written consent for the person to represent his interest.
- The person is authorized by law to give consent for the participant (e.g. parent of a minor, legal guardian, foster partner and power of attorney.
- For pre-service and urgent claims, the person may be:
    - The person's immediate family member (e.g., spouse, parent, child, sibling);
    - The participant's legal guardian;

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 percentage is known as coinsurance.

There is also a family *deductible*. Once the family *deductible* 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 – the percentage is known as coinsurance.

Copayments

This is the payment you make for certain services at the time you receive care (for example, for a doctor office visit or a prescription drug.) Usually, the deductible does not need to be met before the copayment (or copay) applies. The copay goes towards meeting your out-of-pocket and towards meeting your deductible.

Covered Services or Plan Services

Covered Services is reasonable and customary services for medically necessary services and supplies that are:

- Recommended by the treating physician; and
- Required in connection with a treatment of accidental bodily injury, disease or pregnancy, or in connection with the care and treatment of a newborn dependent child prior to release from **a hospital.**

Out-of-Pocket Maximum

Once you or a family member pays the out-of-pocket limit for covered medical expenses in a calendar year, the Plan pays all future eligible charges at 100% for the remainder of the calendar year.

There is a similar limit for your family's out-of-pocket expenses. Once the family limit is reached, the Plan pays 100% of all future covered charges for your entire family for the remainder of the calendar year.

Certain expenses do not count towards the out-of-pocket limit. These include:

- *Copayments*; and
- *Coinsurance* payments paid at 50% under the Low deductible

If you are enrolled in the Low Deductible Plan, there are two separate out-of-pocket maximums: one for medical and one for prescription drugs.

Participant

Participant is an employee who has satisfied the eligibility and participation requirements specified for each health and welfare plan and whose participation has not been terminated under any applicable provision of the plan.

Finding a in-network provider

Use the BCBTX member website or call the number on the back of your medical ID card to confirm you are using an in-network provider or facility – even if you were referred from another in-network provider or facility.

COORDINATION OF BENEFITS (COB)

When there is another medical 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 and Medicare is always secondary when the participant is enrolled in group health coverage – even when over the age of 65 but still actively working.

When there is Medicare Coverage

If you or one of your dependents has *Medicare* medical coverage due to a disability, your benefits payment under this Plan will be reduced by the amount *Medicare* pays or would have paid if *Medicare* coverage had been in effect. *Medicare* benefits are generally available to an individual who has been receiving Social Security disability benefits for two years. You should apply for *Medicare Parts A and B*

through your local Social Security Administration office, as soon as you are eligible. In addition, if you are eligible for *Medicare* due to a disability, *Medicare* will also be the primary coverage for your *Medicare* eligible spouse or dependent.

HEALTH SAVINGS ACCOUNT

The Choice Saver HDHP medical plan offers you the opportunity to contribute to a separate Health Savings Account ("HSA") administered by Fidelity. You must be enrolled in the Choice Saver HSA plan to contribute funds to the HSA account. The HSA is not subject to ERISA.

The Health Savings Account (HSA) is your own bank account that reimburses you for certain eligible medical expenses. Unlike the Flexible Spending Account, you never lose access to the amounts you contribute to your HSA. You can take the HSA with you if you retire from Genesis Energy or terminate your employment.

At a Glance

- You may also contribute pre-tax dollars each paycheck up to the total allowable amount.
- You aren't required to contribute to an HSA, but participation is encouraged so you can benefit from the tax advantages of this plan.
- Your contributions go into your account and can be used to reimburse yourself for eligible expenses as they occur.
- When you need care, you may choose to pay your claims with your HSA funds or pay the total amount directly out-of-pocket and save your HSA funds for another time.
- HSA funds do not expire, so you can roll them over from year to year and take them with you if you leave the Company.
- The HSA is not subject to ERISA.

Participation

If you choose to participate in the HSA plan, you can select one of the following coverage levels:

- HSA Individual
- HSA Family

Company-Paid Contributions

• HSA Individual: up to $500 per year
• HSA Family: up to $1,000 per year

The Company's contribution will be made throughout the year on a pro-rata basis. Employer contributions will be deposited as soon as administratively possible, provided the HSA account is open and ready for funding. Genesis Energy reserves the right to terminate its contributions in future years; however, any contributions that have already been made to your account cannot be forfeited.

Total 2025 Contribution allowed by IRS

(Employee + Company)

• Individual $4,150
• Family $8,300

If you are age 55 or older, you can contribute an additional $1,000 to your HSA annually in catch-up contributions.

Before you decide to participate in an HSA, here are some additional facts you should know:

- If you are married and your spouse participates in a different HSA-compatible plan, you must each have your own account if you both want to make contributions.
- If you or your spouse participates in a traditional health care flexible spending account or HRA, neither of you will be eligible to contribute to an HSA.
- If you are contributing to the HSA and are 55 and older, you can make up to $1,000 in catch up contributions per year.
- You cannot contribute to an HSA if you are enrolled in Medicare or Medicaid.
- You cannot contribute to an HSA if you are considered a dependent on someone's income tax return (does not include filing jointly with a spouse).
- There is a penalty if you contribute more than the maximum allowed for the year. You may withdraw the excess funds (as taxable income) without penalty up until April 15 of the following year.
- If you use your HSA to pay for non-qualifying medical expenses or for the medical expenses of someone who is not your spouse or federal tax dependent, the reimbursement will be considered taxable income to you and be subject to an additional 20% tax penalty. The reimbursement is not subject to the additional 20% tax penalty if you are age 65 or older or are deemed disabled.
- Need to save more than the limit? You can still use the Health Care FSA; however, it will be administered as a "limited purpose" account. See the "Flexible Spending Account" section for more information.

Important Information About Your HSA Contributions

Genesis Energy provides contributions to the Health Savings Account (HSA) of each employee who is enrolled in the Blue Cross Blue Shield Choice Saver HSA ("HDHP") medical coverage option. In addition, you can make your own contributions to your HSA up to the annual limits established by the IRS. (Consult your personal tax advisor to learn more about your HSA contribution limits.)

For your convenience, you can elect to have your HSA contributions deducted directly from your paycheck on a pre-tax basis. Otherwise, you can contribute to your HSA on an after-tax basis directly with Fidelity.

If you are an eligible employee, you must establish your HSA with Fidelity within 30 days of your hire date (or, for existing employees, within 30 days of the date you enroll in the HDHP). To open your HSA, you need to create an account in Fidelity at www.401k.com . If you open your HSA within this timeframe, you will have the opportunity to make HSA payroll deductions and receive the full employer HSA contribution, up to the contribution limits established by the IRS.

If you establish your HSA within 30 days of your HDHP enrollment, you will receive the HSA contributions you elected to have deducted from your payroll. Failure to open the account within 30 days of the enrollment or within 30 days following the end of annual enrollment, or your employment is terminated

prior to establishing an HSA through Fidelity, will result in a refund of your attempted HSA payroll deductions as standard taxable income, subject to withholding and payroll taxes income, and your HSA contribution will be cancelled. Lastly, you will also forfeit any employer contributions that would have been deposited if the employee had established the has for the remainder of the plan year. You will not have the opportunity to receive employer HSA contributions until the next annual enrollment period.

If you have any questions, please contact: Fidelity at 800-835-5097.

DENTAL

Your dental coverage is another key component to your health coverage. Dental coverage helps pay for necessary treatment to maintain healthy teeth. This section describes generally how the dental plan component of this plan works and provides a list of covered services and supplies.

Blue Cross Blue Shield of Texas is the claims administrator for dental and the Company is the plan administrator of the group health plan. Together they determine the payments and types of benefits for you and your dependent dental care needs. The Plan Administrator decides who is eligible to participate in the plan, not the claims administrator.

More detailed information about covered services and benefit provisions (deductible, coinsurance, out-of-pocket maximum and other cost-sharing features), can be found in the latest documents available online at www.genesisenergy.com/human-resources:

- Blue Cross Blue Shield of Texas Dental Plan Benefit Booklet
- Blue Cross Blue Shield of Texas Summary of Benefits & Coverage – Dental Plan

At a Glance

- You may use the provider of your choice, but if you use an in-network provider you will receive higher benefits than if you choose an out-of-network provider.
- The dental plan provides benefits for a wide range of dental services – from preventative and routine care to treatment of serious dental problems.
- Your contributions for your coverage are deducted from your paycheck on a pre-tax basis.

Coverage Tiers

If you choose to participate in the medical plan, you select one of the following coverage tiers:

- Employee only
- Employee & spouse
- Employee & child(ren)
- Employee & family

What you pay for coverage

What you pay for dental coverage includes:

- Your payroll deductions

- Calendar year deductible;
- Your coinsurance payments; and
- Costs in excess of maximum benefit limits.

Payroll Deductions

You and Genesis Alkali share in the cost of your medical coverage. Your payroll deductions are based on the option you select and the number of dependents you enroll. You have three coverage options:

Payroll deductions are determined annually. You can review current payroll deductions in Dayforce, in the Benefits Guide which is posted online at www.genesisenergy.com/human-resources or by contacting the Benefits Department. Rates for the upcoming plan year are available during annual enrollment.

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 percentage is known as coinsurance.

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 portion of costs you are responsible for paying and are determined by the type of dental procedure being performed (preventive, basic or major).

Covered Services or Plan Services

Covered Services is reasonable and customary services for medically necessary services and supplies that are:

- 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.

Participant

Participant is an employee who has satisfied the eligibility and participation requirements specified for each health and welfare plan and whose participation has not been terminated under any applicable provision of the plan.

Find an in-network provider

Use the BCBTX member website or call the number on the back of your medical ID card to confirm you are using an in-network provider or facility – even if you were referred from another in-network provider or facility.

VISION

Your vision coverage is a voluntary plan that offers coverage for vision care services and vision care materials. As a participant with vision coverage, you can use benefits at any eye care location, with enhanced benefits when using a VSP preferred provider.

Vision Service Plan (VSP) the claims administrator for dental and the Company is the plan administrator of the group health plan. Together they determine the payments and types of benefits for you and your dependent vision care needs. The Plan Administrator decides who is eligible to participate in the plan, not the claims administrator.

More detailed information about covered services and benefit provisions, can be found in the latest documents available online at www.genesisenergy.com/human-resources:

- VSP Certificate of Coverage
- VSP Vision Benefits Summary

At A Glance

- VSP has a network of providers who offer discounted fees and wholesale prices for routine eye exams, lenses and frames.
- Should you use a non-network provider, the plan partially reimburses your costs.

Overview

The vision plan (VSP) is available to help maintain the health of your eyes. This is an optional plan paid for by the employee.

Participation

If you choose to participate in the vision plan, you select one of the following coverage levels:

- Employee Only
- Employee & Spouse
- Employee & child(ren)
- Employee & family

FLEXIBLE SPENDING ACCOUNTS

This section highlights how the Flexible Spending Accounts (FSA) works. An FSA can assist you with saving money. By using pre-tax dollars to pay certain eligible health care and dependent care expenses, you save on taxes each year. Inspira Financial (Inspira) is the claims administrator for FSAs the Company is the plan administrator.

At a Glance

- There are two types of FSAs – the health care account and the dependent care account (the dependent care FSA is not subject to ERISA).
- The health care account is administered as a "limited purpose" account if you are enrolled the HDHP medical coverage options..
- You may elect to set aside pre-tax money in one or both accounts through payroll deductions.
- When you incur eligible health care or dependent care expenses, you may reimburse yourself with tax-free money.
- You save by paying less in income tax.

Overview

The FSA offers you a way to pay certain health and dependent care expenses with pre-tax dollars. Because your contributions are not taxable, you save by paying less in income tax.

There are two types of FSA accounts – the health care account and the dependent care account:

- The health care FSA helps you pay for certain medical, prescription drug, dental, vision, and hearing expenses not covered by any health plan.
- The dependent care FSA helps you pay for eligible dependent care expenses.

You fund your accounts through pre-tax paycheck deductions. These funds are credited to your FSA account(s). For the health care FSA, funds are loaded onto a debit card. For the dependent care FSA, you are reimbursed you are reimbursed with tax-free dollars after you file a paper claim.

You have 14 ½ months to use the money in your FSAs – from January 1 through March 15 of the following year for any expenses that were incurred by December 31. If at the end of that time the funds remaining in either account exceed the total amount of your claims – in other words, you have a balance remaining – you forfeit the excess amount as required by Internal Revenue Service (IRS) regulations. There are deadlines for incurring expenses and filing claims as outlined in this section.

Participation

Each year during annual enrollment, you decide whether or not to enroll in the account(s) and how much to contribute during the coming year. You can set aside money in one or both accounts. You do not have to be enrolled in a medical or dental plan to participate in either account.

Please refer to the Participation Section for details on eligibility, enrolling, and when coverage begins and ends.

How Flexible Spending Accounts Work

Estimate Your Expenses

When you enroll, you determine how much you expect to spend on health and/or dependent care expenses for the coming year. It is important to estimate these expenses carefully, because if you fail to utilize the funds you have set aside within the timeframe specified, you may lose those remaining funds.

Decide How Much to Contribute

- You decide how much to contribute for the coming year.
- For the health care FSA, you can set aside up to $3,300 a year (updated as of 2025).
- For the dependent care FSA, you can set aside the lesser of:
    - $5,000 ($2,500 if you are married and file a separate federal income tax return),
    - Your earned income for the tax year, or
    - If you are married at the end of the year, your spouse's earned income for the tax year.

Under federal law, if you participate in the dependent care FSA and your spouse participates in a similar account through his or her own employer, your combined contributions to the account may not exceed $5,000. This limit applies regardless of the number of dependents receiving care.

If you and your spouse file separate income tax returns, the most each of you may contribute is $2,500. In addition, if you are married, your dependent care FSA contributions may not exceed the annual income of the lower paid spouse.

In general, you may not use the dependent care FSA if your spouse does not work outside the home. There are two exceptions: if your spouse does not work outside the home and is physically or mentally unable to care for himself or herself, or if he or she is a full-time student.

In these cases, for purposes of calculating the contribution limit, the Internal Revenue Service considers your spouse's earned income to be:

- $250 a month ($3,000 a year) if you have one dependent
- $500 a month ($6,000 a year) if you have two or more dependents

If you participate, it is your responsibility to comply with the federal limits.

Incurred Expenses

The FSAs reimburse you for eligible expenses you or your dependents incur from January 1 through December 31. Any expense incurred before or after those dates does not qualify for reimbursement. Expenses under the plan are incurred when you are provided with the care or service that gives rise to the expenses, not when you are formally billed or charged, or when you pay for the care.

Receive Reimbursement

For reimbursement, utilize your FSA debit card or submit a claim form and supporting documentation in accordance with the provisions outlined in this section.

You are reimbursed for the eligible expense with tax-free dollars:

- From the health care FSA, you are reimbursed up to the total amount you elect to contribute for the year – even if you have not yet had the full amount taken from your paycheck.
- From the dependent care FSA, you are reimbursed up to the amount in your account on the date your claim is processed. Your dependent care account is shortly after the deduction is made from your paycheck.

If You Terminate Your Employment

Any expense incurred after you terminate employment is not eligible for reimbursement. Only expenses incurred while you are an active employee and contributing are eligible (unless you continue participating in the health care account through COBRA).

Two Accounts Treated Separately

One additional consideration when estimating your expenses: the health care account and dependent care account are separate. This means you cannot use money deposited in your health care account to pay dependent care expenses, and vice versa.

Changing Your Contributions

In general, you cannot change the amount of your contributions during the year unless you have a change of status that affects your participation. Any request for change must be consistent with your status change (i.e., disqualification of a dependent for coverage would not be an acceptable reason to increase your deposits). Changes must be made within 31 days of the change in status event. If you do not meet the deadline, you may not make any changes until the next open enrollment period, unless you have another qualifying change in status. Please refer to the Participation section for more details.

Forfeiture of Contributions

If you do not use the entire balance in your account(s) by the end of the 14 ½ months, the IRS requires you to forfeit the remaining funds. This money is not available for future expenses or a refund.

A Word about Taxes

FSA contributions reduce your taxable income – meaning you pay less in taxes. Your contributions, as well as the money reimbursed to you, are not subject to federal income taxes, Social Security (FICA) taxes, and most state and local income taxes.

Rules vary, and state and local tax laws are subject to frequent change.

How These Accounts Can Help You Save

The following chart illustrates the potential tax savings when using a FSA:

If You Contribute:	Your Tax Savings Could Be:
$500	$113
$1,000	$226
$3,000	$679

These tax savings are based on a 15% income tax rate and the Social Security (FICA) rate of 7.65%. If your income tax rate is higher, and/or you also pay state and local taxes, you could save even more. Contact your personal tax advisor for more information about the tax savings available to you.

Effect of Pre-Tax Contributions on Your Other Benefits

Pre-tax contributions reduce the Social Security taxes you pay. Therefore, the eventual Social Security benefit you may be eligible to receive may be reduced. For more information, contact your local Social Security Administration office.

The Health Care FSA

In most cases, you can use the health care FSA to reimburse your and your eligible dependents' health-related charges that meet all of these conditions:

- Incurred for medical care, including the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body;*
- Incurred while you actively participate in the health care FSA; and
- Not reimbursed under any other health, dental or vision plan.

*If you are enrolled the HDHP, please note that the health care FSA will be administered as a "limited purpose" FSA. This means that the account will only reimburse qualifying dental and/or vision expenses, as required by federal tax law, until your medical deductible has been satisfied. Once the annual deductible for your HDHP has been met, the account will reimburse all IRS-approved medical expenses.

Eligible Dependents

In addition to yourself, you can use your health care FSA to pay out-of-pocket expenses for your eligible dependents. This includes your spouse and your unmarried dependent children or stepchildren, so long as the dependents receive over half of their support from you (the health care FSA can be used for all children who meet the ACA's adult child eligibility rules). The dependents do not need to be enrolled in the group health plan for you to use your FSA on their eligible health care expenses.

Eligible Expenses

The following are examples of eligible expenses the health care FSA reimburses. There may be other expenses that qualify for reimbursement. (Remember that if you are enrolled in the HDHP medical coverage option, the health care FSA will reimburse only dental and vision expenses!)

- Acupuncture
- Alcohol or drug dependency treatment and treatment centers
- Band Aids, elastic bandages and wraps

- Dental expenses that are not cosmetic and are not covered or that exceed the dental plan limits
- Charges that exceed usual and customary limits
- Contraceptives
- Hearing care expenses, including those for examinations and hearing aids
- Insulin and diabetic supplies
- Medical and dental deductibles, coinsurance and copays for office visits and prescriptions
- Vision care expenses such as examinations, treatments, eyeglasses and contact lens expenses not covered by a benefit plan
- Wheelchairs, walkers, canes, braces and supports

Expenses Not Covered

The following are examples of expenses that are not eligible for reimbursement from the health care FSA:

- Cosmetic treatments or drugs, unless prescribed to treat a congenital defect or accident reconstruction, including:
    - Hair loss treatments or transplants
    - Face Lifts
    - Piercings
    - Teeth whitening or bleaching
    - Health club memberships or exercise classes to promote general health
- Household help, even if recommended by your doctor because you are unable to perform housework
- Individual health or dental insurance contributions
- Over-the-counter drugs and medicines that do not require a prescription from a physician
- Weight loss programs not associated with a diagnosed disease or ailment or dietary supplements taken to promote general health, such as vitamins or herbs

The eligible and ineligible expenses listed here are only examples. Other expenses may be eligible for reimbursement. To learn more see IRS Publication 502 at www.irs.gov

The Dependent Care FSA

You can use the dependent care account to pay for many types of dependent care. However, to qualify as an eligible expense, all the following must be true:

- Care for your dependent(s) must be necessary for you and your spouse to work, look for work, or go to school full time. In other words, expenses are not eligible if they are for services provided while you are out for the evening socially or on vacation.

- The expenses must be incurred during the calendar year in which you participate.

- If the care is provided by a day care facility that cares for six or more individuals at the same time, the facility must be licensed and have a tax ID.

- Your care provider is not a person you claim as a dependent on your federal tax return (a son or daughter who provides care must be at least age 19). In addition, you must provide your caregiver's name, address and Social Security number or taxpayer identification number when you file for reimbursement. You also must provide this information on your federal income tax return, unless your caregiver is a church or other religious organization.

Eligible Dependents

An eligible dependent is a child younger than age 13 whom you claim as a dependent on your income tax return. An eligible dependent can also be an adult dependent (a disabled spouse, a disabled child, or an elderly parent) who meets all of these requirements:

- Depends on you for at least half of his or her support;
- Is physically or mentally unable to care for himself or herself; and
- Resides with you for more than half the year.

Eligible Expenses

The dependent care account can be used to pay for IRS-specified dependent care expenses you incur so that you may work or attend school full time. The following are examples of the types of expense for which you can use the dependent care account:

- Dependent care provided in your home, including a nanny or assistant care. The provider may be a relative (provided he or she is not your child under age 19, your spouse or any other person whom you claim as a dependent).
- Dependent care provided outside your home, including care provided in a neighbor's home or in an approved day care center, provided your dependent regularly spends at least eight hours a day in your home. For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for six or more individuals must comply with all federal, state and local regulations governing day care centers.
- Before and after school programs for children under age 13.
- Day camp services for children under age 13, if the primary reason for being there is the care and well-being of the child and it is custodial in nature, and not educational.

Expenses Not Covered

Some expenses do not qualify for reimbursement through the dependent care account, including:

- Dependent care expenses incurred before or after your FSA participation begins and ends.
- Expenses you claim as an after-tax dependent care tax credit on your federal income tax return or expenses paid by any similar reimbursement plan.
- Expenses to attend kindergarten grade or beyond.
- Care provided by a round-the-clock nursing home.
- Services provided by your spouse, your child under age 19, or someone you or your spouse claim as a dependent on your tax return.

- Child or dependent care provided while you and/or your spouse are doing volunteer work (even if a nominal fee is paid).
- Transportation expenses to and from the care site.
- Expenses for overnight camp.
- Day care provided by an unlicensed facility if that facility cares for six or more individuals.

The eligible and ineligible expenses listed here are only examples. Other expenses may be eligible for reimbursement. To learn more, see IRS Publication 503 at www.irs.gov

Applying For Reimbursement

Health Care Account Expenses with the FSA Card

The Inspira FSA card is similar to a debit card because it electronically accesses your health care account to pay for eligible expenses. All enrollees in the health care account will receive a FSA Card. You can use the card at qualified merchant locations where MasterCard is accepted. The PayFlex Card is accepted at health care merchants as well as non-healthcare merchants who have implemented an inventory information approval system (IIAS). Qualified merchants may include physician and dental offices, hospitals, mail order prescription vendors, hearing and vision care providers. As you incur eligible health care expenses, you simply present the FSA Card for payment. The system will then validate that your coverage is active and that you have available funds to cover the transaction.

Using the FSA Card is a great way to help relieve you of filing claims. However, it is important that you keep all itemized receipts and Explanation of Benefits (EOBs) in the event the information is requested by Inspira to comply with IRS regulations. An itemized receipt includes the date of purchase or service, name of merchant or service provider, description of product or service and amount of purchase.

Health Care Account Expenses without the FSA Card

For expenses incurred where the PayFlex Card is not used, you may submit a claim for reimbursement online at www.*inspirafinancial.com* Claims or complete a paper claim and fax or mail it to PayFlex. Your claim must include any explanation of benefits (EOB) you receive from BCBSTX, and/or an itemized bill for services not covered by insurance, which includes the name of the service provider, cost of the service, description of the service, patient name, and date of service.

The full annual amount you elect to contribute to your account (less any previous reimbursements) is available for reimbursement, regardless of the amount contributed to date. Contributions continue to be deducted from your pay to cover any claims already fully reimbursed from the health care account.

Dependent Care Account Expenses

As you incur dependent care expenses, you may submit a claim for reimbursement online at www.inspirafinancial.com or complete a paper claim and fax or mail it to Inspira. Your claim must include your provider's bill or itemized receipt, as well as your dependent care provider's name, address, and Social Security or federal tax identification number.

For dependent care FSAs claims, only your current account balance is available. If the dependent care services exceed your account balance, you receive a partial reimbursement. You receive the unreimbursed portion of the claim as you make additional contributions to your dependent care FSA throughout the year.

Filing Deadline

You may file claims any time after you incur the expense. You have until April 30 to file claims that incurred in the prior year before December 31.

If a Claim Is Denied

If disagreements arise regarding your claim, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a decision. Please refer to the Administrative Information section for details on the appeal process for the health care FSA.

The appeals process described in the Administrative Information section does not apply to the dependent care FSA. If your claim for reimbursement under the dependent care account is denied, you may appeal the decision to Inspira by sending a written request for review. Your claim for reimbursement under the dependent care account will be reviewed and you will be notified in writing of a decision and the reason for it.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Personal concerns can affect so many aspects of your well-being – physical, emotional, spiritual and even financial. That's why the Company offers you and your family members the EAP – a free counseling and referral service you can turn to when you need help. This section describes generally how the EAP component of this plan works.

At a Glance

- This service is available 24 hours a day, 7 days a week, 365 days a year.
- The service is paid for by the Company. There is no cost to you.
- You can access the EAP website where you can read articles, contact a consultant, listen to audios, take self-assessments, order or informational material.
- You can also reach a professional counselor using a toll-free number. Your counselor will follow through with whatever support and information you need to answer your question or address your concern.

Overview

The Employee Assistance Program (EAP), offered through SupportLinc, is available to help you and your eligible family members receive confidential, professional, counseling and referral services. The Company provides this benefit to you at no cost.

Participation

All employees and their family members may participate.

How the EAP Works

Confidential, professional assistance is available 24 hours a day, seven days a week by calling (888)881-LINC(5462). The EAP assists with a variety of personal concerns. It can help assess a problem, provide professional counseling services, provide confidential care, educate, provide follow-up care, and refer you to additional resources, if needed. The EAP consultant will ask you questions, discuss the issues, and assess the situation. Your consultant may talk you through the problem and develop an action plan over the phone. Other times, you and the consultant may decide you need more specific information to help you resolve your concern. Your consultant will follow through with the support and information you need to answer your question or address your concern.

If your problem requires in-depth counseling, you and/or your family member may be referred to another professional for additional assistance. Any costs associated with a referral to another professional are your responsibility. The additional services may be covered under your medical plan if you or a family member participates in the Company medical plan. If you or your family member doesn't participate in the Company medical plan, but is covered by another medical plan (for example, a spouse's employer's medical plan), that medical plan may cover some or all of any additional services. Be sure to make sure the counselor or professional you are referred to is in-network with your medical plan.

You may also access the SupportLinc website at www.supportlinc.com, with new account code of 'genesis'. With access to the website, you can read articles, contact a consultant, listen to audios, take self-assessments, order or informational material. The site helps you get the answers you want in the format you prefer.

The service is confidential. All contacts via telephone, in person, or via the internet are private unless mandated by law. SupportLinc is mandated to report any instances of harm to self or others, including abuse or neglect of a child or vulnerable adult.

Here are some examples of the things the EAP can help you with:

- Family, including childcare referrals, parenting problems, elder day care, serious illness or death of a family member, aging parents, marital difficulties such as divorce, communication facilitation, conflict resolution, domestic violence issues, dual career issues;
- Conflicts at work, such as job dissatisfaction, time management, balancing work and family, conflicts with authority;
- Alcohol or drug abuse;
- Stress or anxiety;
- Depression;
- Financial, such as budgeting or credit management; and/or
- Limited legal advice, such as wills or family law.

Applying for Benefits

The Company covers the cost of services provided by the EAP. If disagreements arise regarding coverage or services provided to you by the EAP, every effort is made to resolve them quickly and informally.

However, if that is not possible, formal procedures are in place so that you may appeal a decision. Please see the Administrative Information section for more information.

LIFE INSURANCE, AD&D AND DISABILITY

Your health & welfare plan provides income protection for you and your family. These programs are in the form of Life insurance, Accidental Death & Dismemberment, Short-term disability and Long-term disability. These programs are insured and administered by Prudential and have separate policies that govern the plan.

More detailed information about these plans can be found in the latest documents available online at www.genesisenergy.com/human-resources:

- Life, AD&D, Optional Group Life Certificate of Coverage – Genesis Energy and Alkali employees, excluding Drivers
- Life, AD&D, Optional Group Life Certificate of Coverage – Genesis Energy Drivers
- Short-term Disability Certificate – Alkali employees
- Short-term Disability Certificate – Energy employees
- Short-term Disability Certificate – Marine Mariners
- Long-term Disability Certificate – 50% of 60% Benefit (Alkali employees only)
- Long-term Disability Certificate – Energy employees

BUSINESS TRAVEL ACCIDENT INSURANCE

If you die or are seriously injured in an accident while traveling on business for the Company, your dependents' financial security could be seriously affected. The Company automatically provides you with business travel accident coverage. This section describes generally how the Company business travel accident benefits work.

At a Glance

- The Company provides full-time employees with coverage, at no cost to you.
- The plan pays a person's claims up to the dollar limits set by law.
- The plan pays a percentage of that benefit if you suffer a significant loss from an accident that takes place while you are traveling on Company business.

Overview

Business travel accident coverage provides benefits to you or your designated beneficiary if you are traveling on business for the Company and are involved in an accident that results in your death or serious injury.

Participation

Participation in the business travel accident plan begins on your date of hire. See the Participation section for additional details on eligibility, and when coverage begins, ends.

Benefit Summaries

Complete information about your business travel accident benefits can be found in the following document:

- National Union Fire Insurance Company of Pittsburg, PA – Business Travel Accident Policy

LEGAL & ADMINISTRATIVE INFORMATION

This section provides important legal and administrative information about your health and welfare benefits. You'll find important addresses and phone numbers for plan and claim administrators, as well as information about your legal rights when it comes to claims and steps you should take when a claim is denied. This section also provides information about your privacy rights.

Plan Identification and Funding

This is an employee welfare benefit plan governed by ERISA.

Plan Name	**Genesis Energy Health & Welfare Benefits Plan**
Plan Number	505
Plan Year	January 1 – December 31
Employer Identification Number	80-0321477
Benefits Provided	Medical, Dental, Vision, Flexible Spending Accounts, Life, AD&D, Short-Term Disability, EAP, and Long-Term Disability
Plan Administration	The Plan Sponsor serves as the plan administrator under ERISA. Certain administrative function (including claims processing) are delegated to third-party administrators and insurers.
Plan Funding	Funded through insurance contracts, the general assets of the plan sponsor, and employee contributions

Plan Sponsor, Administrator and Agent for Service of Legal Process

The Company sponsors the benefit plans described in this booklet, is the plan administrator, and is the designated agent for service of legal process. You may call the Human Resources Department at (800) 284-3365 or the appropriate third-party administrator or insurance carrier with any questions you may have about these plans. If one of these resources cannot answer your question, you should write to the Human Resources Department at this address:

Genesis Energy, LLC
811 Louisiana
Ste 1200
Houston, TX 77004

For Genesis Energy employees, the plan sponsor for the following plans: medical, dental, vision, flexible spending accounts, Life, AD&D, EAP and BTA is:

Genesis Energy, LLC
811 Louisiana

Ste 1200
Houston, TX 77004

For Genesis Alkali employees, the plan sponsor for Short-Term disability and Long-term disability is:

Genesis Alkali, LLC
1735 Market Street
Philadelphia, PA 19103

Important Contact Information

Benefit	Who to Contact	Phone Number	Website/Email
Medical Group No: HDHP 245204 / PPO 086304	Blue Cross and Blue Shield of Texas	**(800) 521-2227**	**www.bcbstx.com**
Prescription Drug Group No: Rx3675	CVS Caremark	**(844) 910-3890**	**www.caremark.com**
Health Savings Account	Fidelity	**(800) 835-5097**	**www.401k.com**
Dental Group No: 327262	Blue Cross and Blue Shield of Texas	**(800) 521-2227**	**www.bcbstx.com**
Vision Group No: 30043154	Vision Service Plan (VSP)	**(800) 877-7195**	**www.vsp.com**
Flexible Spending Accounts Group No: 116234	Inspira Financial	**(800) 284-4885**	**www.inspirafinancial.com**
Life and AD&D Insurance Group No: 45697	Prudential	**(800) 524-0542**	**www.prudential.com**
Long-Term and Short-Term Disability Group No: 45697	Prudential	**(877) 367-7781**	**www.prudential.com**
Profit Sharing and Retirement Savings Plan	Fidelity	**(800) 835-5097**	**www.401k.com**
Legal Services Group No: 203795	LegalShield	**(800) 654-7757**	**www.legalshield.com**
Identity and Data Theft Protection Group No: E0011429	NortonLifeLock	**(800) 607-9174**	**www.mynorton.com**
Employee Assistance Program	SupportLinc	**(888) 881-LINC (5462)**	**www.supportlinc.com** New Account code: genesis
General Benefits Information	BenefitsConnections Team	**(877) 241-9624**	**genesisenergy.com/human-resources** **BenefitsConnections@genlp.com**

Keep Your Address Updated

In order to protect your family's rights, you should keep your employer and the plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator. Further you should provide the Company and the plan administrator with such information and evidence as may reasonably be requested from time to time for the purpose of administering the plan. Address changes can be updated in Dayforce.

Other Participant Responsibilities

Any notices required or permitted to be given under this plan shall be deemed given if directed to such address and mailed by regular United States mail. Notwithstanding anything in the preceding sentence to the contrary, the plan, the Company and the plan administrator may provide any notice electronically, or otherwise, consistent with the requirements of ERISA. Neither the plan administrator nor the Company shall have any obligation or duty to locate you or your covered dependent. In the event that you or your covered dependent becomes entitled to a payment under the plan and such payment is delayed or cannot be made because the current address according to the Company's records is incorrect, the amount of payment, if and when made, shall be that determined under the provisions of the plan without consideration of any interest which may have accrued.

Changes to the Plan

The Company reserves the right to amend, suspend, or terminate these plans at any time and for any reason.

If any material changes are made in the future, you will be notified about them. Benefits will be paid according to the provisions of each plan.

Official Plan Documents

If this book inadvertently states anything that disagrees with the official plan documents or insurance contracts that govern each component of these plans, the plan documents or insurance contracts will be used to determine your benefits.

Claims Process

Claims for health and welfare plan benefits must be filed with the appropriate claim administrators and insurance companies. The procedures for initially applying for plan benefits are found in the relevant benefit program summaries.

As part of the claims administration process, the claim administrators or insurance companies:

- Pay claims for benefits due under the plan
- Provide written explanations of the reasons for denied claims
- Handle claimant requests for reviews of denied claims

The applicable claim administrator has the authority to make the final decision on denied claims with respect to the insured programs under the plan: the long-term disability plan, life and AD&D plans, long-term care plan, and business travel accident plan.

Under the ERISA, you have the right to appeal a denied claim. You must exhaust the plan's claims and appeal processes before filing a lawsuit in federal court.

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.

Types pf 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 *physician*, 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.

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 15-day 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 30-day 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.

How to Appeal a Claim Decision

If you disagree with the Claims Administrator's decision after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. The Claims Administrator will provide you with complete information about how to submit your appeal (including the applicable mailing address or email contact). Please be aware that you may be required to provide the following information:

- The patient's name.
- The plan identification number.
- The date(s) of health care service(s).
- The provider's name.
- The reason(s) you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

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

After this first-level review has been completed, you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

After this first-level review has been completed, you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

Statute of Limitations for All Benefit Claims

If you wish to file a lawsuit, you must pursue at least one ERISA appeal first.

Then, you must file your lawsuit within 12 months of the date you filed your final-level appeal under the applicable benefit program's claims and appeal procedures, unless a shorter deadline is described in a benefit summary or insurance policy.

Subrogation and Reimbursement

Overview

The plan does not cover expenses for services and supplies relating to an illness, injury, disability or death as a result of the actions of a third-party that may be liable for such expenses. This exclusion from coverage also applies to expenses for which payment may be made under any automobile policy, homeowner's policy, workers' compensation or similar insurance coverage. If a plan pays or provides benefits for you or your dependents, the plan is subrogated to all rights of recovery which you or your dependent have, and may use your rights to recover money through judgment, settlement or otherwise from any person, organization, or insurer. For the purposes of this provision, subrogation means the substitution of one person or entity (the plan) in the place of another (you or your dependent) with reference to a lawful claim, demand or right, so that he who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

If you or your dependent recover money from any person, organization, or insurer for an injury or condition for which the plan paid benefits, you or your dependent agree as a condition of receiving benefits under the plan to reimburse the plan from the recovered money for the amount of benefits paid or provided by the plan. That means you or your dependent will pay to the plan the amount of money recovered by you through judgment, settlement or otherwise from the third-party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the plan.

Right to Recovery by Subrogation or Reimbursement

You or your dependent agree as a condition of receiving benefits under the plan to promptly furnish to the plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the plan in protecting and obtaining its reimbursement and subrogation rights. You, your dependent or your attorney, if applicable, will notify the plan before settling any claim or suit so as to enable the plan to enforce its rights by participating in

the settlement of the claim or suit. You or your dependent further agree not to allow the reimbursement and subrogation rights of the plan(s) to be limited or harmed by any acts or failure to act on your part.

Refund of Benefit Payments

If the claim administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or was made in error, the plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the claim administrator may deduct any refund due it from any future benefit payment.

Non-Assignment of Benefits

Rights to benefits, payments and coverage under this Plan may not be assigned by any Participant or Beneficiary to any third party, expect to the extent required by applicable law (such as pursuant to the Qualified Medical Child Support Order). This means that you are not permitted to assign to another person, corporation or other organization (including a healthcare provider) your rights under the Plan to receive or to assert a claim for benefits or payments due under the Plan or to assert any other claim to enforce your rights and obligations owed to you under the terms of the plan. Any unauthorized assignment of a Participant or Beneficiary's rights under the Plan will be void.

The Plan and its agents make payments directly to providers of Covered Services, whether at the direction of a Participant or Beneficiary or otherwise. No such payment, however, is intended to or shall constitute a transfer or assignment of any right belong to a Participant or Beneficiary or confer any other rights under the Plan or applicable law.

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, the *Claims Administrator* 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.

Plan Interpretation

The plan administrator has full discretionary authority to interpret and apply the provisions of the plan and this summary. While the summary is intended to be complete and accurate, remember that it is only a summary of the plan's provisions. In interpreting this summary, the plan administrator will rely on the governing plan document. In the event of any conflict between this summary and its governing document, the plan document will always control. The explanations in the summary cannot alter, modify, or otherwise change the controlling plan document, nor can any rights accrue by reason of any statements or omissions in the summary.

With the exception of denied claims which may be appealed as described in the section entitled claims procedures, the plan administrator's decisions regarding the interpretation of the plan document and summary are conclusive and binding on all persons. The plan administrator may, however, delegate some of its interpretation and decision-making authority to the insurer or claim administrator of the plan. Benefits under this plan will be paid only if the plan administrator or its delegate decides in its discretion that the applicant is entitled to them.

You are encouraged to review the plan documents. You may contact the Benefits Department so they can make the documents available and arrange a time and place for your review of the documents.

Insured Benefits

Benefit plans provided pursuant to an insurance policy under which an insurer pays all benefits from the first dollar of claims (i.e. a fully insured policy) will be subject to the following rules:

- Benefits promised under a fully insured policy will be paid only by such insurer; and
- The Company will not be responsible for any benefits which are subject to a fully insured policy.

Benefit plans described in this summary which are fully insured shall be subject to any additional terms, limitations or conditions contained in the applicable insurance policy.

No Contract of Employment

You should also understand that this summary is not intended to create or to be construed as a contract between the Company and their employees as to any matter, including the provision of benefits described herein. The benefits described in this summary are discretionary and may be changed or terminated at any time for any reason and in any manner not prohibited by law as the Company deems appropriate. Such changes may be made with respect to active employees, former employees, current retirees, future retirees and beneficiaries. Questions of intent, interpretation or application should be referred to the Director of the Human Resources Department. Only a member of the executive management team is authorized to amend the plan and to speak on behalf of the Company on matters relating to this summary and the plan.

Reservation of Rights

This summary has been prepared to acquaint you with your benefits under the plan and generally describes the provisions currently in effect. Although every effort has been made to assure that this information is accurate, it describes the benefits in general terms and should be used only as a guide. In the event of any ambiguity, discrepancy, inconsistent interpretation or application and/or decision in specific circumstances, the official text or terms of the plan document will govern. Similarly, any oral or

written representation that you may receive cannot override, reverse or supplement the provisions of the plan document.

Note that each employee and/or dependent(s) and his/her (their) physician are responsible for making decisions regarding the quality of care and the course of treatment, irrespective of whether the plan provides coverage for such care or treatment or recommends other care or treatment.

Your Rights as a Plan Participant

As a participant in the plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, 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 Benefits Security Administration ("EBSA").
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report (Form 5500). The plan administrator is required by law to furnish each participant with a copy of this summary annual report (SAR) each year.

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.

Prudent Actions by Fiduciaries

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

Enforce Your Rights

If your claim for a benefit under the plan 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, you may file suit in federal court if:

- You request a copy of plan documents or the latest annual report (Form 5500) from the plan and do not receive it within 30 days. 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 control of the plan administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part and you have exhausted the plan's internal claims process. You may also file suit in state court.
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may seek assistance from the U.S. Department of Labor.
- The court will decide who should pay court costs and legal fees. For example, 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 frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

BENEFIT DOCUMENTS

Complete information about your medical, dental and vision benefits (what is covered, how it's covered) can be found in the following documents:

Benefits Guide – A high-level summary of the entire benefits program and includes information on both health, welfare, and retirement plans. It should be used for quick access to high-level information but is not intended to be explicit or provide finite details.

Summary of Benefits Coverage (SBC) – a snapshot of health plan's costs, benefits, covered health care services and other important features like cost-sharing, exclusions, and limitations in easy-to-understand terms.

Benefit Booklet – Similar to the SBC but it provides more detailed information about covered health care services, required authorizations, limitations, and exclusions.

In the event there is a conflict between this Summary Plan Description and underlying benefit documents like the Benefits Guide, SBC or Benefits Booklet, the SPD will govern. Genesis Alkali reserves the right to terminate or modify the benefits, include employee/dependent eligibility to participate, at any time. Your participation in the Plan is a guarantee of continued employment.

PLAN DOCUMENT

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 *Green River HR Department*.

DEFINITIONS

ACCIDENT

A sudden, unforeseen event that causes an injury.

AFFIDAVIT OF SAME-SEX DOMESTIC PARTNERSHIP

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

AFFIDAVIT OF TERMINATION OF SAME-SEX DOMESTIC PARTNERSHIP

A written notarized statement that attests that the employee and the same-sex domestic partner have terminated their same-sex domestic partnership.

ALLOWABLE REIMBURSEMENT AMOUNT

The maximum amount of charges allowed under the Plan, as determined by the *Claims Administrator*.

AMBULATORY SURGICAL CENTER

A facility equipped to handle surgical procedures that require *hospital* facilities, but do not require a *hospital* stay. To qualify, a surgical center must:

- Be established, equipped and operated for the performance of surgical procedures by doctors; and
- Have an organized medical staff and equipment and supplies not usually available to a doctor outside a *hospital*, including operating and recovery rooms, diagnostic facilities and emergency equipment, full-time registered nurses and a written agreement with a nearby *hospital* to accept patients who develop complications.

BIRTH CENTER

An ambulatory facility providing comprehensive maternity care to patients expected to have an uneventful pregnancy with a normal, uncomplicated childbirth. The facility must be licensed, directed by a *physician* who is a specialist in obstetrics and gynecology and have arrangements with a nearby *hospital* to accept patients if emergencies occur.

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 *copayment* is satisfied. For example, 80% *coinsurance* means a plan would pay 80% of covered expenses after any *deductible* and you would pay the remaining 20% of covered expenses (and your *deductible*, if applicable).

COPAYMENT

The dollar amount you pay for covered services at the time you receive care.

CUSTODIAL CARE

Services and supplies furnished mainly to help an individual in the activities of daily life rather than to provide medical treatment; or is care that can be safely and adequately provided by persons who do not have the technical skills or a covered health care professional. It includes room and board and other institutional care or services. The individual does not have to be disabled to receive *custodial care*. These services and supplies are *custodial care* regardless of by whom they are prescribed, recommended or performed.

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 *deductible*s – individual and family.

DURABLE MEDICAL EQUIPMENT

Items that are:

- Made to withstand repeated use and are not consumable or disposable;
- Made and used in the treatment of a disease or injury;
- Appropriate for use in the home;
- Not used by individuals who do not have an injury or disease;
- Are not used for altering air quality or temperature; and
- Not used for exercise or training.

This equipment includes, but is not limited to, crutches, wheel chairs and *hospital* beds. This does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, message devices, overbed tables, elevators, communication aids, vision aids or telephone alert systems.

EMERGENCY CARE

Treatment for a recent and severe medical condition, including, but not limited to, severe pain, that would leads a prudent person to believe that his or her condition is of such a nature that the failure to get immediate medical attention could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily functions;
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

EXPERIMENTAL

A drug, service, device, procedure or treatment is *experimental* if:

- There are insufficient data outcomes available;
- Required approval by the Food and Drug Administration (FDA) has not been granted for marketing;
- A recognized national medical society or regulatory agency has determined that it is *experimental*, investigational or for research purposes;
- The device or treatment is in clinical trials; and
- Protocols state that the device, procedure or treatment is *experimental*, investigational or for research purposes.

EXTERNAL REVIEW ORGANIZATION (ERO)

An independent review organization that is accredited by URAC (a healthcare accrediting organization) or by a similar nationally recognized accrediting organization.

HOME HEALTH CARE AGENCY

An agency that:

- Mainly provides skilled nursing services and other therapeutic

devices; and

- Is associated with a professional group that:
  - Has at least one *physician* and one registered nurse;
  - Has full time supervision by a *physician* or registered nurse;
  - Keeps medical records;
  - Has a full-time administrator; and
  - Meets licensing requirements.

HOSPICE

An agency or organization that:

- Provides counseling and incidental medical services to *terminally ill* patients;
- Meets any licensing or certification standards; and
- Provides a coordinated program of *medically necessary* home health, outpatient and inpatient services provided by an interdisciplinary team and directed by a *physician*.

HOSPITAL

A facility that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons;
- Is supervised by a staff of *physicians*;
- Provides 24 hour a day registered nurse service; and
- Is not mainly a place for rest, the aged, drug addicts, alcoholics or a nursing home.

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* to prevent, evaluate, diagnose or treat an illness, injury, pregnancy, disease or its symptoms and meets the following criteria:

- Follows generally accepted standards of medical practice;
- Not primarily for the convenience of you and your covered dependent, *physician* or health

care provider;

- Clinically appropriate; and
- There is not a less intensive or appropriate diagnostic or treatment alternative that could have been used to produce equivalent therapeutic or diagnostic results.

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

Generally accepted standards means standards that are based on creditable scientific evidence recognized by the medical community.

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*.

OUT-OF-POCKET MAXIMUM

Your share of covered medical expenses including *deductible*s and *copayments*. After you reach your *out-of-pocket maximum*, a plan generally pays 100% of most covered charges for the rest of the calendar year. Certain *deductible*s and *copayments* do not count towards the out-of-pocket limit as mentioned in this SPD. There are two types of *out-of-pocket maximums* – individual and family. A new *out-of-pocket maximum* applies each calendar year.

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.

PRE-CERTIFICATION

A process where the *Claims Administrator* is contacted before certain services are provided, such as hospitalization or outpatient surgery, to determine if the services are considered covered expenses under the Plan.

PRESCRIPTION DRUGS

- A drug, biological, compounded prescription or contraceptive device that, by federal law, may only be dispensed by prescription and that are required to be labeled: "Caution: federal law prohibits dispensing without a prescription;
- An injectable contraceptive drug prescribed to be administered by a paid health care professional; and
- An injectable drug prescribed to be self-administered or administered by another person, but not a health care professional, such as insulin.

TERMINALLY ILL

A medical prognosis of six months or less to live.

WORKERS' COMPENSATION

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