A GUIDE TO YOUR

2018 EMPLOYEE BENEFITS

CINER

Welcome to your 2018 Employee Benefits Guide

Ciner Resources is a recognized leader in our industry with a first class approach in all that we do. Our Total Rewards package – a combination of pay and benefit programs – is designed to attract and retain the best talent. We believe people are our greatest asset so we provide a comprehensive set of options, designed to promote health and wellness, while giving you choices about the types and levels of protection that you want to help you live life well.

The benefit plan options described in this booklet give you the flexibility to select the benefits you and your family really need. Each year, you have the opportunity to review your benefit options and make choices that best fit you and your family.

For additional detail on your benefits such as Benefit Summaries, Summary of Benefits and Coverage (SBCs) and Summary Plan Descriptions (SPDs), visit the employee portal – Ciner Benefit Center at cbizesc.com/ciner. Paper copies are also available upon request and free of charge by contacting your local Human Resources office or calling Ciner's Benefits Department at 770-375-2300, option 6 or emailing benefits@ciner.us.com. This portal is available to you 24/7/365 and contains the most up-to-date benefit plan information.

Benefit	Who Pays for Coverage?
Medical Insurance	Ciner and You
Health Reimbursement Account (HRA)	Ciner
Health Savings Account (HSA)	Ciner and You
Wellness Program	Ciner
Telemedicine Benefit	Ciner and You
Dental Insurance	Ciner and You
Vision Insurance	You
Flexible Spending Accounts (FSA)	You
Basic Life Insurance	Ciner
Basic Accidental Death & Dismemberment Insurance	Ciner
Supplemental Employee and Dependent Life Insurance	You
Short-Term Disability Insurance (STD)	Ciner
Long-Term Disability Insurance (LTD)	Ciner
Supplemental Insurances	You
Employee Assistance Program	Ciner
Health Advocacy	Ciner

IMPORTANT REMINDERS

Medical Plan Partnerships and Options

Ciner partners with Continental Benefits to administer the medical plans. The provider network is Aetna Signature Administrators (ASA) for all medical benefits and WellDyne administers the pharmacy benefits. The telemedicine benefits are through MDLive, also under the Continental Benefits umbrella. There are no changes to this arrangement for the 2018 plan year except enhanced communications from Continental Benefits are expected. You will see better detail on a completely revised Explanation of Benefits (EOB) and a redesigned, user-friendly website which includes virtual ID cards, viewable benefit plan information and cost transparency tools. Watch for more details to be released.

For 2018, Ciner will continue to offer the three medical plan options originally introduced in January 2017. All three medical plans use the same provider network and have the same covered benefits and exclusions. The three plans share costs differently. During annual enrollment, we suggest that you look closely at all plan details (see the chart on page 7) to make a personal decision as to what plan works best for you and your family members. You should weigh the following:

- **Deductible Amount** – the amount of money you must pay before the plan begins to pay;
- **Coinsurance percentage** – the amount the plan pays once the deductible is met;
- **Prescription Drug Benefits** relative to your prescription drug needs;
- **Out of Pocket Maximum** – The amount you pay for covered medical expenses in a plan year through deductible and coinsurance before the plan pays 100% of covered medical expenses for the remainder of the plan year;
- **HRA Roll Over Balance**—the amount that remains in your account as of the end of the calendar year; and
- **Premium** - The amount you pay out of your paycheck each pay period.

You can locate or confirm an Aetna network provider at **ASAlookup.AetnaSignatureAdministrators.com**. **You may also call HealthAdvocate at 866-799-2731 and let them do all the legwork for you!** Note: By using a network provider, you can take advantage of the negotiated discounts and help avoid balance billing.

Health Fund Accounts and Flexible Spending Accounts

Health Savings Account (HSA)

You have the opportunity to participate in a Health Savings Account (HSA) if you choose to participate in Ciner's Green Plan. With an HSA, you and Ciner can both contribute. For 2018, individuals with single coverage can contribute up to ***$3,450*** (up $50 from 2017), including Ciner contributions and earned wellness incentive rewards. Similarly, individuals with family coverage can contribute up to ***$6,900*** (up $150 from 2017). Individuals 55 or older as of the end of 2018 can contribute an additional ***$1,000***. The account is individually owned, similar to your 401k account. Contributions to an HSA are pre-tax and can be used to pay for eligible health expenses as you go or saved for later and even invested. Estimate your contribution carefully so you don't lose out on any tax advantage offered or any Ciner contribution. The amount you choose to contribute, the Ciner funded portion ($250 single/$750 family) and your earned wellness incentives that Ciner awards directly into your HSA (up to $750 single or $1,000 family) counts towards your maximum annual contribution.

Limited Purpose Flexible Spending Accounts

If you enroll in the HSA-compatible medical plan option (Ciner's Green Plan) and have out-of-pocket dental or vision expenses that you want to pay on a pre-tax basis, you can also elect to enroll in the Limited Purpose Flexible Spending Account. While the HSA is used to cover health expenses, funds are only available for reimbursement up to what has been contributed to the account at that point in time. A Limited Purpose FSA (LFSA) can be used to cover dental and vision charges from day one. If you anticipate that you will have dental and vision expenses prior to accumulating the funds in your HSA, you might consider also enrolling in the LFSA. Additionally, if you want to save your HSA dollars, but know you will have these additional health expenses, you could enroll in a LFSA to further reduce your taxable earnings. The LFSA is a 'use-it-or-lose-it' account and balances in excess of $500 at the end of the year will be forfeited if services were not incurred during the plan year .

IMPORTANT REMINDERS

Health Fund Accounts Administration

HRAs, HSAs, FSAs and LFSAs

All Health Reimbursement Accounts (HRA), Health Savings Accounts (HSA), Flexible Spending Accounts (FSA), and Limited Purpose Flexible Spending Accounts (LFSA) continue to be administered by Discovery Benefits. When you first enroll, you receive one debit card covering all of your accounts . Your debit card is valid for three years so don't discard it at the end of the year. You will have access to all your account balances online (discoverybenefits.com) or by phone (866-451-3399). The online option is mobile-friendly and an App is available.

You have control and flexibility over how your HRA dollars are spent. Medical and pharmacy claims are not automatically withdrawn from your HRA. Instead, you will use your debit card to choose when your HRA funds are used; providing options to pay directly for smaller out-of-pocket costs and save HRA funds for larger expenses or use manufacturers discount coupons at the pharmacy.

Please keep your receipts to document your expenses in accordance with IRS requirements. Discovery Benefits could ask you for receipts related to your HRA, FSA and LFSA expenses but not your HSA expenses. You are responsible for providing receipts to the IRS related to your HSA expenses should you be audited. NOTE: For 2018, the maximum annual contribution to a Medical FSA or LFSA is ***$2,650*** (up $50 from 2017 maximum).

If you change medical plans for 2018, any HRA balance remaining from 2017, will be forfeited. Also, if you are in the Green Plan and have an HRA rollover balance from 2016, you will be able to access those HRA funds after meeting $1,350 (up $50) of the deductible for single coverage or $2,700 (up $100) of the deductible for family coverage based on the 2018 IRS minimum deductible for qualified high deductible health plans.

401(k)

A Roth 401(k) option and a Traditional 401 (k) are available under the Ciner 401(k) Retirement Plan. In a Traditional 401(k), you contribute income pre-tax, and then pay taxes on the funds when you withdraw them during retirement. With a Roth, you pay the taxes upfront so you can make withdrawals tax-free (including earnings) during retirement when certain conditions are met.

As of January 1, 2018, Traditional (non-Roth) after-tax contributions to the 401(k) plans will no longer be permitted. Any current after-tax balances will remain in your account, but no future after-tax contributions will be allowed. If you contribute to a Traditional (non-Roth) account after-tax currently, you may want to consider increasing the pre-tax and/or Roth 401(k) contributions. Ciner will not automatically redirect an existing after-tax contribution—you must take action to continue the current contribution level.

Also, you will have a new opportunity to defer a portion (up to 25%) of your Ciner Incentive Compensation Plan (CICP) bonus into your 401(k) Plan account. Ciner will match those contributions at the same percentage (100% of the first 4% and 50% of the next 2% of eligible pay). The bonus deferral election will count towards the 2018 IRS limit. The deferral limit allows individuals to contribute up to 25% of pay (up to the 2018 IRS limit of $18,500 or $24,500 for individuals aged 50 and older). Bonus deferral elections can be made through February 15, 2018 for your 2017 CICP payment which is expected to be paid in March 2018. If you take no action, Ciner will assume you do not want any portion of your CICP contributed to the 401(k).

To take advantage of the Roth feature, enroll in the 401(k), redirect any current after-tax contributions or make a bonus deferral, log onto the Merrill Lynch website (benefits.ml.com) or call 1-800-229-9040.

IMPORTANT REMINDERS

Wellness and Health Advocacy—One # to Call for Benefit Support

Wellness programs are an important part of Ciner's medical plans. All plan options cover preventive care and generic preventive prescriptions at 100%. We partner with HealthAdvocate for our wellness incentive program. In addition, HealthAdvocate helps Ciner employees and dependents with advocacy assistance for claims research, provider searches, health cost estimates by service and can answer questions about the medical, dental and vision benefits.

With the wellness program – those enrolled in an HRA or HSA can earn wellness incentives by achieving health goals, completing certain preventive services and participating in Ciner wellness challenges. The program also offers wellness incentives to your enrolled spouse. Ciner contributions are made to either the HRA or HSA fund, depending on your enrollment.

Furthermore, we continue to offer a wellness discount to reduce your 2018 annual payroll contributions by $240 if you complete a Personal Health Profile (PHP), also known as an online health risk assessment, through HealthAdvocate, and an annual biometric screening between November 1, 2017 and February 28, 2018. If the risk assessment and biometrics are not completed with Ciner's wellness partner, HealthAdvocate, the discount will not be applied. Individuals who currently receive the wellness discount will have the payroll reduction automatically extended through February 2018. If the risk assessment and biometric screenings are not completed prior to March 1, 2018, the discount will be removed. Other individuals who complete the Personal Health Profile and biometric screening by the end of February will receive the discount retroactive to January 1, 2018.

An additional benefit, is a Benefit Gateway service through HealthAdvocate. You have a single toll-free number available to you to connect to any Ciner insurance partner. If you have a question about the medical, pharmacy, telemedicine, wellness, dental, vision, EAP, etc. plans, you only have to remember one number to call. A live Advocate will answer and either assist directly or transfer you to the appropriate partner to answer your question.

The Gateway Benefits number with HealthAdvocate is 866-799-2731.

Spousal Surcharge

Spousal insurance surcharge programs are prevalent in company programs as a method to ensure that when spouses have access to another employer's group insurance, they strongly consider that employer's health plan versus enrolling in the available Ciner plan options. Ciner employees must pay an additional cost to cover a spouse who has the option to elect health care coverage through another employer. The additional cost, or surcharge is $100 per month. If this applies to you, you will want to consider how the additional cost may impact your plan choice.

During the online enrollment process you will complete an affidavit indicating whether your spouse has other coverage available. If an individual indicates that no such coverage is available and at any point that is determined to be a misrepresentation of fact, it will be treated as an intentional act and subject to retroactive termination of the ineligible individual's coverage, repayment of claims/premiums and disciplinary action up to and including termination of employment.

Coordination of Benefits

It is important that you confirm your insurance coverage with all your healthcare providers so that your medical claims are filed and processed correctly by Continental Benefits. If you or a family member that is covered by a Ciner -sponsored medical option have alternate or additional healthcare (through Medicare, another employer's plan or Wyoming Miner's Hospital Benefits for example) that provides benefits, you need to share the details of that coverage with Continental Benefits. You will be able to confirm applicability (yes/no) of 'other' coverage during the online enrollment process. If you answer, 'yes', you will be sent a form to provide details about the 'other' coverage.

IMPORTANT REMINDERS

Retiree Medical and Dental Deferred Election

The current Ciner practice of requiring that you cover yourself and/or your spouse under the Ciner medical and/or dental plans immediately prior to retirement in order to be eligible for retiree benefits has inadvertently forced some employees to elect coverage unnecessarily or prematurely. Therefore, for individuals eligible for retiree medical or dental benefits and retiring on or after January 1, 2018, you no longer need to cover yourself and/or your spouse under the Ciner medical and/or dental plans immediately prior to retirement for you and/or your spouse to be eligible for retiree benefits.

Also, individuals eligible for retiree medical or dental benefits and retiring on or after January 1, 2018, no longer need to elect coverage for yourself and/or your spouse immediately at the time of retirement. You may choose to decline retiree coverage at the time of retirement but still have an opportunity to elect Medical and/or Dental retiree benefits at a later date. This affords you the option to choose Ciner-sponsored retiree benefits or any other coverage that may be available to you at time of retirement (i.e. a working spouse's employers plan).

On the election form at the time of retirement, you will simply indicate if you wish to defer your retiree coverage election to a later date. You will be required to confirm your dependent's demographic data (name, date of birth, etc.) at that time as only your dependents at time of retirement will be eligible for Ciner-sponsored retiree benefits at a later date.

HOW TO ENROLL?

How to Enroll

Step 1: Review Benefit Enrollment Material

Carefully review the following benefit material in this guide to help with your annual benefit decisions and enrollment.

Step 2: Log On and Enroll

- Log onto the Ciner Benefit Center website at cbizesc.com/ciner.
- Enter your User ID. This is the first initial of your first name, the first initial of your last name, and the last four digits of your Social Security Number. For example: John Smith, SSN 123-45-6789 would be js6789
- Enter your Password, which is your birth date (e.g. August 27, 1972 would be entered as 08271972). You may change your password once you log in.
- Once you have logged in to the enrollment portal, you can review additional benefit information by clicking on the "Library" link on the left hand side of the page. Once you have reviewed all benefits and are ready to enroll, click on the "Enroll" link in the "Your Benefits" section of the Main Menu.
- Follow the instructions to enroll. You will begin by updating your personal information, including your dependents and beneficiaries. Then, make your 2018 elections, or waive coverage for certain benefits. Begin with your medical options and continue reviewing each of your options in order. With each benefit, you will see the coverage you will have for 2018 if you do not make any election changes. If you are electing any life or disability benefit that requires approval from the carrier (Evidence of Insurability or EOI), your request for coverage will prompt Aetna Life Insurance Company to mail you an EOI packet which contains a web address for you to complete and submit your EOI online with Aetna.

Review and update your beneficiary information.
While enrolling in your 2018 health and welfare benefits, please take a moment to add your beneficiaries for your life and accident insurance coverages. Once you have logged into the Benefits Center, cbizesc.com/ciner, click on the "Update" link in the "Dependents/Beneficiaries" section on the left hand side of the Main Menu. When enrolling in the 401(k) account, you will also be asked to add your beneficiaries by logging onto benefits.ml.com.

Step 3: Review and Confirm your Elections

- Once you have completed your enrollment, a confirmation statement will appear on the page with the 2018 benefits and coverages you have selected. Please review this information carefully!
- If the information is accurate, click "Confirm". You will then receive a confirmation number. **Write this number down, print a copy, or email yourself a copy and keep it for your records.**
- If the information is incorrect, click "Change".
- You may change your enrollment as many times as necessary during your enrollment period. You will receive a new confirmation number with each change. Once you receive your confirmation number, you have finished the enrollment process.

<u>It is important to note that your enrollment is NOT complete until you receive your confirmation number.</u>

If you have any technical issues or questions OR if you would prefer to enroll via phone, please call 1-888-883-3599.

Representatives are available to assist you 9:30 AM EST to 7:00 PM EST, Monday through Friday (except Holidays).

WHO AND WHEN TO ENROLL?

Employee Eligibility

All active, part-time and full-time employees regularly scheduled to work 30 hours or more per week are eligible to participate in Ciner benefit plans.

All other employees, including but not limited to temporary or seasonal workers and contract employees not meeting the 30 hour average, are not eligible to participate in Ciner-sponsored benefit plans.

Dependent Eligibility

You must enroll yourself in order to enroll your spouse or any dependents. Upon your enrollment, must enter your dependent's information (name, date of birth, Social Security number, relationship, gender and address) in order to enroll them and you will be asked to provide verification for your dependent(s) such as a birth or marriage certificate. Your dependents can include the following:

- Your legal spouse (not legally separated, divorced or common-law)
- Your children to age 26 including biological children, legally adopted children and step children - coverage extends to the end of the month in which your child turns 26
- Your unmarried children of any age who are dependent upon you for support and incapable of supporting themselves due to disability or illness

If you and your Spouse both work for Ciner

If you and your spouse both work at Ciner and have no eligible dependent children, it may be more economical for each of you to choose employee only health care coverage. If you have eligible dependent children, one of you can waive coverage under the plan and the other can elect family coverage. If you both are eligible for coverage as employees and elect the coverage, benefits will be paid according to the coordination of benefits (COB) rules.

It is also important to note that if a family member works for Ciner, they may not be covered as a dependent under the dependent life insurance plan or dependent AD&D insurance. Furthermore, any dependent children may only be covered by one employee under the dependent life insurance plan or dependent AD&D insurance plan.

Be sure to review your family's coverage options before choosing duplicate coverage.

Healthcare Reform

You may have heard about the health insurance marketplaces. Individuals who are not offered qualified healthcare coverage through their employer may be eligible for government subsidies to help pay for health insurance premiums for plans purchased in these marketplaces (based on income level and number of dependents).

To find out more about the insurance marketplaces, visit healthcare.gov.

Coverage Effective Date and Election Changes

If you are a new hire and provided you enroll in your first 30 days of employment, benefits are generally effective beginning the first of the month following or coinciding with your date of hire. Enrolled dependents are effective on the same day you become effective. Enrollment outside the first 30 days may result in a delay in your effective date or ineligibility until the next plan year. Ciner's plan year is January 1 through December 31 with an annual enrollment period that typically falls in November.

According to IRS guidelines, the benefit coverage you elect to pay for on a pre-tax basis - such as medical, dental and vision coverage - must stay in effect for the entire plan year. However, you may be able to change your benefits during the year if you experience a qualified life event. Qualified life events include, but are not limited to:

- Marriage, divorce, legal separation or annulment
- Birth, adoption or placement for adoption of an eligible child
- Death of a dependent
- Change in your spouse's or child's employment status that affects eligibility for benefits
- Dependent reaching the age of ineligibility for coverage under your plan (age 26)

If you experience a qualifying event and wish to enroll or make a change in benefits, you must request the enrollment or change no later than 30 days after the event occurs in order to qualify. All election changes must be consistent with the qualifying event. For example, if you give birth to a child during the year, you may add your child to the medical plan but you could not cancel your vision coverage for yourself.

To request special enrollment, or obtain additional information, contact the Employee Benefits Department. You can update your enrollment due to a life event change by logging into the Benefit Center at cbizesc.com/ciner or calling 888-883-3599.

Unless you experience a qualifying event, Open Enrollment may be your only opportunity to make benefit elections for the year.

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider? Contact Continental Benefits (Group # CB360) at 855-347-2638 or continentalbenefits.com or HealthAdvocate Benefits Gateway at 866-799-2731

Medical Insurance – Continental Benefits

Ciner offers **three** medical plan options administered by Continental and utilizing the Aetna Signature Administrators PPO network. One plan is a Health Reimbursement Account (Blue Plan), one is a High Deductible Health Plan (Green Plan) and one is a Traditional PPO (White Plan).

Features of all medical options:

- Preventive health care services from a network provider are covered at 100% and are not subject to a deductible.
- For each covered person, the deductible is limited to the plan "Individual" deductible. If you elect to cover yourself and at least one more family member, your total deductible expenses for all family members will not exceed the "Family" deductible. Any combination of covered family members can meet the family deductible.
- Any licensed provider can provide services; however, you will receive a much greater benefit by going to a network provider with a negotiated relationship with Aetna.
- Prescriptions for certain generic Preventive medications are covered in- network at 100% and not subject to the plan deductible.
- If you complete a Biometric Screening and an online Member Health Risk Assessment (entering all biometric screening results), you are eligible for a premium discount of $20 per month. The discount is not to exceed $240 annually.

Features of the Blue Plan:

- All non-preventive eligible pharmacy expenses are covered at varying cost shares (varies by prescription tier or category) up to a maximum amount per prescription when filled by an in-network provider.
- All non-preventive health care expenses are subject to the calendar year deductible before the insurance company pays any portion of the expense. Once you meet the deductible, you pay only a percentage of the covered expense (your coinsurance) and no more than the out-of-pocket maximum. If you reach the out-of-pocket limit, the insurance company covers 100% of any covered expense for you and/or your family members for the remainder of the plan year.
- Contributions Ciner makes (including those you earn through participation in the HealthAdvocate wellness program) towards your Health Reimbursement Account can be used towards your deductible and the out-of-pocket maximum, which includes the plan deductible. All covered pharmacy expenses count towards your out-of-pocket limit as well.

Features of the Green Plan:

- All non-preventive eligible pharmacy expenses are covered at 90% after you've met your annual deductible and when prescriptions are filled by an in-network provider.
- All non-preventive health care expenses are subject to the calendar year deductible before the insurance company pays any portion of the expense. Once you meet the deductible, you pay only a percentage of the covered expense (your coinsurance) and no more than the out-of-pocket maximum. If you reach the out-of-pocket limit, the insurance company covers 100% of any covered expense for you and/or your family members for the remainder of the plan year.
- Contributions you and/or Ciner make (including those you earn through participation in the HealthAdvocate wellness program) towards your Health Savings Account can be used towards your deductible and the out-of-pocket maximum, which includes the plan deductible. All covered pharmacy expenses count towards your deductible and out-of-pocket limits as well.

Features of the White Plan:

- All non-preventive eligible pharmacy expenses are covered at varying copays (varies by prescription tier or category) when prescriptions are filled by an in-network provider.
- All copays, deductible and coinsurance expenses apply to the out-of-pocket maximum.

To find Aetna medical providers, visit:

- ASAlookup.AetnaSignatureAdministrators.com
- Click *Medical*
- Enter your search criteria (Provider Type, Zip code, etc.)
- Select *Advanced Search* as needed
- Click Search

Or call HealthAdvocate at 866-799-2731

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider? Contact Continental Benefits (Group # CB360) at 855-347-2638 or continentalbenefits.com or HealthAdvocate Benefits Gateway at 866-799-2731

PLAN NAME	Blue Plan		Green Plan		White Plan	
Annual Contribution	**Annual HRA Contribution** Ciner deposit made upon enrollment Earned incentive deposits made each payroll		**Annual HSA Contribution** Ciner deposit made prorata each payroll Earned incentive deposits made each payroll		**Annual Contribution**	
Ciner contribution - Individual	$250		$250		Not applicable	
Ciner contribution - Family	$750		$750		Not applicable	
Earned wellness incentive - Individual	up to $750		up to $750		Not applicable	
Earned wellness incentive - Family	up to $1,000^		up to $1,000^		Not applicable	
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Coinsurance	Plan pays 80%	Plan pays 60%	Plan pays 90%	Plan pays 60%	Plan pays 80%	Plan pays 60%
Individual Deductible *(per calendar year)*	$3,000		$3,000		$2,500	
Family Deductible *(per calendar year)*	$6,000		$6,000		$5,000	
Individual Out of Pocket Maximum *(Includes deductible and prescription expenses)*	$6,000	$9,000	$5,000	$8,000	$5,000	$10,000
Family Out of Pocket Maximum *(Includes deductible and prescription expenses)*	$12,000	$18,000	$10,000	$16,000	$10,000	$20,000
Preventive Office Visits	100%; Deductible waived	40%*	100%; Deductible waived	40%*	100%; Deductible waived	40%*
Primary Care Office Visit	20%*		10%*		$25	
Specialist Office Visit					$50	
Telemedicine Visit - MDLive	$40 consult fee	Not applicable	$40 consult fee	Not applicable	$25 copay	Not applicable
Inpatient Hospital	20%*	40%*	10%*	40%*	20%*	40%*
Outpatient Surgery						
Emergency Room	20%*		10%*		20%*	
Ambulance						
Urgent Care Visit						
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Retail Prescription Drugs *(30-day supply)*	*$ limits are per script*					
Preventive	100%; Deductible waived	Not Covered	100%; Deductible waived	Not Covered	100%; Deductible waived	Not Covered
Generic	10% to $25		10%*		$10	
Preferred Brand	20% to $125				$25	
Non-Preferred Brand	30% to $175				$50	
Specialty	50% to $200				$200	
Mail Order Prescription Drugs *(90-day supply)*	*$ limits are per script*					
Preventive	100%; Deductible waived	Not Covered	100%; Deductible waived	Not Covered	100%; Deductible waived	Not Covered
Generic	5% to $50		10%*		$20	
Preferred Brand	15% to $250				$50	
Non-Preferred Brand	30% to $350				$100	
Specialty	50% to $400				$400	

^Earned wellness incentive of $1,000 = up to $750 for Employee + up to $250 for Spouse.

*Coinsurance applies after Deductible is met.

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider? Contact Continental Benefits (Group # CB360) at 855-347-2638 or continentalbenefits.com or HealthAdvocate Benefits Gateway at 866-799-2731

How do I know which medical plan is right for me?

Unsure which medical plan option is the best fit for your needs?

Take a moment to review the utilization scenarios below. The top scenario represents a low to average utilizer with employee only coverage. The bottom scenario represents a high utilizer also with employee only coverage. While the example below represents an employee with single coverage, the impact would be similar at other tiers of coverage (employee + spouse, employee + child(ren) or family). The charts below illustrate projected total annual cost under each plan option (Blue, Green, White). Please note that the Out-of-Pocket expenses shown below are net of the base Ciner health fund contributions and assume the maximum wellness incentive is earned during the plan year.

Employee Only	Blue Plan includes HRA fund		Green Plan includes HSA fund		White Plan no health fund	
Claim Activity	**HRA Fund**	**Your Cost**	**HSA Fund**	**Your Cost**	**Fund**	**Your Cost**
Company Annual Contribution	$250		$250			
Maximum Earned Incentive	$750		$750			
6 Regular Office Visits (estimated $70 each)	($420)	$0	($420)	$0		$150
Preventive Office Visits	$0	$0	$0	$0		$0
1 Specialty Office Visits (estimated $100 cost)	($100)	$0	($100)	$0		$50
4 Mail Order Prescriptions (Pref Brand; estimated $125 each)	($75)	$0	($480)	$20		$200
1 Emergency Room Visit (estimated $500)	($405)	$95	$0	$500		$500
TOTALS	**($1,000)**	**$95**	**($1,000)**	**$520**		**$900**
Employee Annual Contributions	N/A	$2,029	N/A	$1,311	N/A	$1,006
Total Out-of-Pocket Cost		**$2,124**		**$1,831**		**$1,906**

Employee Only	Blue Plan includes HRA fund		Green Plan includes HSA fund		White Plan no health fund	
Claim Activity	**HRA Fund**	**Your Cost**	**HSA Fund**	**Your Cost**	**Fund**	**Your Cost**
Ciner Annual Contribution	$250		$250			
Maximum Earned Incentive	$750		$750			
6 Regular Office Visits (estimated $70 each)	($420)	$0	($420)	$0		$150
Preventive Office Visits	$0	$0	$0	$0		$0
1 Specialty Office Visits (estimated $100 cost)	($100)	$0	($100)	$0		$50
4 Mail Order Prescriptions (Pref Brand; estimated $125 each)	($75)	$0	($480)	$20		$200
1 Inpatient Hospitalization (estimated $20,000)	($405)	$2,075 ded + $2,925 coins maximum	$0	$1,980 ded + $1,700 coins		$2,500 ded + $2,100 coins maximum
TOTALS	**($1,000)**	**$5,000**	**($1,000)**	**$3,700**		**$5,000**
Employee Annual Contributions	N/A	$2,029	N/A	$1,311	N/A	$1,006
Total Out-of-Pocket Cost		**$7,029**		**$5,011**		**$6,006**

UNDERSTANDING YOUR MEDICAL PLAN

Medical Questions? Need to Locate a Provider? Contact Continental Benefits (Group # CB360) at 855-347-2638 or continentalbenefits.com or HealthAdvocate Benefits Gateway at 866-799-2731

Still not sure which medical plan is right for me?

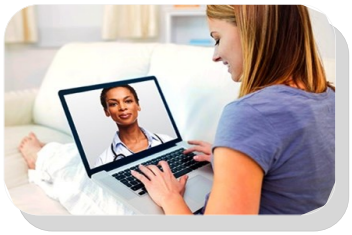
Below is a summary chart highlighting benefit plan differences.

Highlights	Blue Plan with HRA	Green Plan with HSA	White Plan (PPO)
Employee Premium	Highest	Middle	Lowest
Plan Deductible	Deductible applies to all non-preventive medical services before Plan pays, however, HRA Fund reduces deductible and can be used for Prescription expenses	Deductible applies to all non-preventive services before the Plan pays, however HSA Fund can be used to help pay Medical and Prescription expenses	Deductible is not applicable for office services or prescription expenses. Pre-set office visit and prescription copays.
Availability of Copays	There are no copays for services but there is a pre-set $40 telemedicine consultation fee and prescription expenses are capped at set dollar limits per script.	There are no copays for services but there is a pre-set $40 telemedicine consultation fee.	There are pre-set office visit and prescription copays.
Integration with Employer Fund	Immediate access to base HRA Fund on first day of each plan year	Access to pro-rata portion of HSA contribution – only what has been contributed to date	No Company provided funds
Integration with Ciner Wellness Program	Earned Wellness incentives are contributed to your HRA Fund	Earned Wellness incentives are contributed to your HSA Fund	No Company contributions are provided for participation in the Wellness program
Coordination of Benefits	Coordinates with WY Miner's Hospital Benefits	No coordination with WY Miner's Hospital Benefits	Coordinates with WY Miner's Hospital Benefits
Fund Balance	Year-end HRA balance rolls into subsequent plan year provided you re-enroll in the Blue Plan (HRA)	Year-end HSA balance remains in your account for use in subsequent plan years; can accumulate in your individually-owned account for future healthcare expenses; or for use post-65 for non-healthcare related expenses without the withdrawal penalty (subject to applicable taxes at time of withdrawal).	N/A
Tax Benefits	Medical Plan payroll contribution reduces your taxable income but the HRA provides no additional tax benefits to you	Medical Plan payroll contribution reduces your taxable income AND your HSA provides additional opportunity for tax savings	Medical Plan payroll contribution reduces your taxable income
HRA Claim Filing	Claims against your HRA (or rollover HRA balance) are processed via your debit card or filed manually	Claims against your Rollover HRA balance must be filed manually	Claims against your Rollover HRA balance are processed via your debit card or filed manually

UNDERSTANDING YOUR TELEMEDICINE PROGRAM

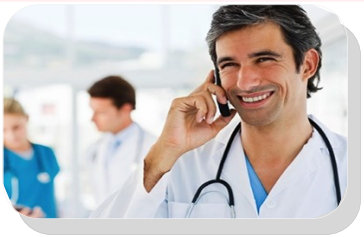
Telemedicine Questions?
Contact MDLIVE through Continental Benefits
855-303-0834 or continentalbenefits.com

MDLIVE provides you with 24/7/365 access to board-certified primary care doctors and pediatricians by secure video, phone, or e-mail. Simply pay the applicable coinsurance or deductible (or use HRA or HSA funds if available) and whether you are at home, at work, traveling, or simply want a more convenient way to see a doctor, MDLIVE is easy to use and available on your schedule anytime, anywhere. MDLIVE is secure, confidential, and compliant with all medical privacy regulations.



Video Consultation

See a doctor using your computer over the internet, via webcam



Phone Consultation

No webcam? No problem! Speak to a doctor over the phone

E-mail Advice

After you've talked with the doctor—use secure email to ask follow-up

FREQUENTLY ASKED QUESTIONS:

Does MDLIVE replace my primary care physician?
MDLIVE is not intended to replace your primary care physician (PCP). For common or chronic conditions, a virtual consultation can sometimes replace a doctor's office or emergency room visit. Communication with your PCP is important for continuity of care.

When should I consider using MDLIVE?

- If your primary care physician is not available or if you need care after normal business hours;
- On weekends or holidays;
- If you're considering an ER or an urgent care center for a non-emergency medical issue; or
- If you're traveling and in need of medical care.

What conditions can MDLIVE doctors treat?
General Health issues like: Allergies, Asthma, Bronchitis, Cold & Flu, Ear Infection, Fever, Headache, Infections, Diarrhea, Poison Ivy, Insect Bites, Rashes, Respiratory Infections, Sinus Infections, Sore Throat, Urinary Tract Infections, etc.

Can I get a prescription from an MDLIVE doctor?
Yes. If the MDLIVE doctor believes a medication is warranted, he or she can write a prescription for non-narcotic medications, which can be sent electronically to your preferred pharmacy.

HOW TO USE MDLIVE:

Are my claims for visits with MDLIVE doctors covered at my in-network rate?
Yes. The claims will be processed by Continental Benefits and you will receive an explanation of benefits (EOB), just as you do when other medical claims are processed.

How much will it cost to use MDLIVE?
For members enrolled in the Blue or Green Plans, the contracted rate for an MDLIVE consultation is $40 and will be applied to any applicable deductible or coinsurance. If members have HRA or HSA funds available, that health fund can cover the cost of the MDLIVE consultation. Individuals enrolled in the White Plan will be charged the $25 physician office visit copay.

When an employee registers for MDLIVE they will be required to list a credit card on file for payment. You are encouraged to register in advance at MDLive.com/CB.

UNDERSTANDING YOUR HEALTH FUND

Health Fund Questions?
Contact Discovery Benefits
866-451-3399 or discoverybenefits.com

Health Reimbursement Account (HRA): What is it?

A Health Reimbursement Account (HRA) is an account funded entirely by Ciner that is used to pay for eligible health care expenses that apply towards your medical deductible and covered prescription drug expenses. The account is managed by Discovery Benefits. As claims are processed, you can choose to use your HRA funds by swiping your HRA debit card at point of service or you can pay the charges out of pocket and 'save' HRA funds for later. When the fund is exhausted, you pay the remaining deductible and then your Blue Plan medical benefits apply (coinsurance, copays, etc.).

How does your HRA work with your medical plan?

1. Funds are deposited into your HRA. The Ciner contribution is available immediately.
2. You or an eligible family member seeks medical or other qualified healthcare services.
3. Claims are processed and paid by Continental Benefits per the plan design, subject to your deductible and coinsurance.
4. You can use your debit card to pay your deductible and coinsurance.

HRA Advantages

- Funded entirely by Ciner.
- HRA fund pays for first dollar services – no waiting for fund to accumulate.
- Year-end balances rollover to the following plan year provided you re-enroll in the Blue Plan.
- May also participate in the full Flexible Spending Account (FSA) for medical, dental and vision expenses.
- Your unused HRA balance can carryover to the next plan year if you've re-enrolled in a Ciner HRA plan.

UNDERSTANDING YOUR HEALTH FUND

Health Fund Questions?
Contact Discovery Benefits
866-451-3399 or discoverybenefits.com

Health Savings Account (HSA): What is it?

A Health Savings Account (HSA) is a personal savings account funded with pre-tax dollars that is used to pay for eligible health care expenses not covered by insurance, such as your medical deductible, prescriptions, dental and vision expenses. The account is flexible so you decide how much to contribute and when to use your HSA funds. As long as you use the funds for qualified healthcare expenses, the funds are not taxed (contributions or withdrawals).

Both Ciner and you can contribute to your HSA. Ciner will contribute a base amount to your HSA each pay period plus additional amounts based upon your successful completion of wellness initiatives and regardless of whether you choose to contribute any of your own money. Beyond the Ciner contribution, you may elect to contribute up to the IRS-specified limits for the calendar year as described below.

In order to receive Ciner contributions (made each payroll and based upon completion of wellness initiatives to date), you must be a benefit eligible employee on the date of each deposit, you must have completed the HSA authorization process and you must not have reached the maximum contribution limit. Once you have setup your account, it belongs to you, so you can take your account and fund balance (including deposited Ciner contributions) with you if you change jobs or retire.

How does your HSA work with your medical plan?

1. Funds are deposited into your HSA. The Ciner contribution and your elected contribution begin to build the account balance.
2. You or an eligible family member seeks medical or other qualified healthcare services.
3. Claims are processed and paid by Continental Benefits per the Green Plan design, subject to your deductible and/or coinsurance.
4. You choose to use the deposited HSA funds to pay for any eligible expenses not paid by Continental Benefits when the claim was processed.

HSA Advantages

- Tax-free employee and employer contributions facilitated through payroll transactions.
- Accumulated HSA funds can be used to pay for current and future qualified health expenses.
- Year-end balances rollover to the following plan year – no "use it or lose it" rule.
- The individually-owned account provides an opportunity to build a significant balance, earn interest and offers investment options.
- May also participate in the Limited Flexible Spending Account (LFSA) for dental and vision expenses.

Examples of Qualified Expenses:

- Deductibles, coinsurance and copays
- Certain over-the-counter medications if you have a written prescription from a physician
- Dental expenses including braces
- Vision expenses including LASIK surgery
- Visit the IRS website at irs.gov and select Publication 969, "Health Savings Accounts and Other Tax Favored Health Plans", for a complete list of eligible expenses

How much can you contribute to your HSA?

Typically, HSA contributions are increased each calendar year. For the 2018 calendar year, considering the Ciner contribution and the maximum wellness incentives available to you, the annual contribution limits are equal to:

Annual contribution	IRS limit*	Ciner contribution**	Earned wellness incentive**	Maximum amount you can contribute *
Individual	$3,450	$250	Up to $750	$2,450
Family	$6,900	$750	Up to $1,000	$5,150

*Employees age 55 or who turn 55 during the plan year can contribute an additional $1,000 in "catch-up contributions" annually.
**Employees are awarded HSA dollars based on successfully completing wellness programs as well as an annual Ciner contribution.

You may use your HSA funds to pay for qualified dependent's eligible health care expenses even if you don't cover that family member on your medical plan. Federal regulations allow you to change the amount you wish to contribute to your HSA during the plan year.

There are certain restrictions on HSA participation depending upon other family member's benefit plan enrollment through Ciner or their own employer as well as receipt of Veteran's Administration (VA) medical benefits.

UNDERSTANDING
YOUR FLEXIBLE SPENDING ACCOUNTS

FSA Questions?
Contact Discovery Benefits
866-451-3399 or discoverybenefits.com

A Flexible Spending Account is an arrangement that permits you to pay for certain out-of-pocket expenses with funds that you have set aside, by payroll deduction, on a tax-free basis. Ciner offers three types of Flexible Spending Accounts: The Health Care Reimbursement Account is for out-of-pocket medical expenses including medical, dental, vision, and prescription drug expenses for you and your dependents. The Limited Purpose Healthcare Reimbursement Account is for out-of-pocket dental and vision expenses for you and your dependents when enrolled in a High Deductible Health Plan (Ciner's Green Plan). The Dependent Care Assistance Account is designed to help you pay for daycare services so that you and your spouse (if married) can work or be a full-time student.

Account Type	Examples of Eligible Expenses	Contribution Limits	Access to Funds	Pre Tax Benefits
Health Care	· Medical Plan Deductibles · Most Insurance Co-payments · Prescription Drugs · Some OTC medicines (only if prescribed by your doctor) · Vision Exams/Eyeglasses/Contacts · Laser Eye Surgery · Acupuncture · Weight Loss Programs · Dental and Orthodontia (Braces) · Birth Control Pills/Devices/Procedures · Chiropractic	Minimum annual contribution is $120. Maximum annual contribution is $2,650.	Allows immediate access to the entire contribution amount from the 1st day of the benefit year, before all scheduled contributions have been made.	Save 20% - 40% on your health care expenses. Save on purchases not otherwise covered by insurance. Reduce your taxable income.
Health Care Limited Purpose (HDHP enrollment required)	· Vision Exams/Eyeglasses/Contacts · Laser Eye Surgery · Dental and Orthodontia (Braces)	Minimum annual contribution is $120. Maximum annual contribution is $2,650.	Allows immediate access to the entire contribution amount from the 1st day of the benefit year, before all scheduled contributions have been made.	Save 20% - 40% on your health care expenses. Save on purchases not otherwise covered by insurance. Reduce your taxable income.
Dependent Care	· Daycare · Day Camp · Eldercare · Before and After School Care	Minimum annual contribution is $120. Maximum annual contribution is $5,000 ($2,500) if married and file separately.	You will be able to submit claims up to your year-to-date accumulated amount in your account. You will only be reimbursed based on your acumulated contribution amount.	Save 20% - 40% on your dependent care expenses. Reduce your taxable income.
"Use it or Lose it" Rule	You should plan your contributions carefully. If you have funds left in your health care FSA at the end of the year, you can roll over up to $500 of your unused funds into the following year. According to IRS guidelines, any other unused money in your FSA will be forfeited.			
Eligibility	You may incur claims beginning January 1st of the current calendar year (or 1st of the month following or coinciding with your date of hire if later) through December 31st of the current calendar year or your termination date if you terminate during the year. All claims must be submitted during the Plan year and/or prior to April 30th of the following plan year (or within 120 days after your employment terminates if earlier). You MUST re-enroll in the FSA every year--FSA elections will not roll over to the following plan year.			

UNDERSTANDING
YOUR HEALTH FUND ACCOUNTS

Questions?
Contact Discovery Benefits
866-451-3399 or discoverybenefits.com

Still not sure how the Health Funds compare?

Below is a summary chart highlighting benefit plan differences.

	Health Reimbursement Account (HRA)	Health Savings Account (HSA)	Medical Flexible Spending Account (FSA)	Limited Purpose Flexible Spending Account (LFSA)
Who contributes?	Ciner	Ciner and You	You	You
Maximum contribution	(includes maximum earned wellness incentives)	(includes maximum earned wellness incentives)		
Single	$1,000	$3,450	$2,650	$2,650
Family	$1,750	$6,900	$2,650	$2,650
Contribution Method	Company Funded	Payroll, by personal check or debit from your personal bank account	Payroll	Payroll
Can contribution election be changed during the year?	n/a	Yes, monthly for any reason	Not unless you have a family status change	Not unless you have a family status change
Timing to access funds	Full annual base amount available on first day. Additional wellness contributions available as earned.	Access to only what has been contributed to account. Company base contributions contributed on a pro-rata basis throughout the year. Additional wellness contributions available as earned.	Full annual election available on first day. Your contributions are deducted on a pro-rata basis throughout the year.	Full annual election available on first day. Your contributions are deducted on a pro-rata basis throughout the year.
Risk of forfeiture	Yes – funds are forfeited when you change plans or terminate employment with Ciner	No – account is individually owned.	Yes – any unused funds over $500 are forfeited. Up to $500 rolls into the next year	Yes – any unused funds over $500 are forfeited. Up to $500 rolls into the next year
What funds can be used for	Medical and prescription drug expenses that are covered under the plan but subject to deductible and coinsurance	Medical, prescription drug, dental and vision expenses. Funds can also be withdrawn for other purposes but may be subject to penalty and taxes.	Medical, prescription drug, dental or vision expenses that are not covered by your insurance	Dental and Vision expenses that are not covered by your Insurance.
Eligibility	Blue Plan	Green Plan	Blue or White Plan	Green Plan
Funds can be invested	No	Yes	No	No
Receipts	Discovery may ask for receipts to verify that expenses are eligible. If you don't respond timely, your debit card will be deactivated and the undocumented reimbursements will become taxable.	You are responsible for keeping the receipts in the event of an IRS audit to verify that the expenses are eligible.	Discovery may ask for receipts to verify that expenses are eligible. If you don't respond timely, your debit card will be deactivated and the undocumented reimbursements will become taxable.	Discovery may ask for receipts to verify that expenses are eligible. If you don't respond timely, your debit card will be deactivated and the undocumented reimbursements will become taxable.
Covered persons	HRA Funds can be used to pay for any person's eligible expense so long as that person is covered on your Ciner medical plan.	HSA Funds can be used to pay for any eligible expenses for any of your eligible tax dependents regardless of whether they are covered on a Ciner medical plan.	FSA Funds can be used to pay for any eligible expenses for any of your eligible tax dependents. The dependents don't have to be covered on a Ciner health plan.	FSA Funds can be used to pay for any eligible expenses for any of your eligible tax dependents. The dependents don't have to be covered on a Ciner health plan.

UNDERSTANDING YOUR WELLNESS PLAN

Wellness Questions?
Contact Health Advocate Benefits Gateway
866-799-2731 or healthadvocate.com/ciner

Earned Wellness incentive: How are the employer contributions earned?

The HealthAdvocate wellness management program is run on a point system. You will earn points throughout the year for completing certain program activities. A full description of the program activities and point allocation follows. The wellness points you earn throughout the year directly correlate to the amount of money Ciner contributes to your health fund (HRA or HSA) for the year.

Ciner will make contributions to your health fund based upon successful completion of the wellness initiatives and activities during the year. Ciner contributions will not exceed the maximum annual contribution allowed by enrollment tier (employee or family). You must be employed on the date of the health fund contribution to be eligible for the contribution.

Wellness With Ciner

The Wellness program with Ciner is a vital part of our overall benefits program. We have partnered with HealthAdvocate, a leading health management services provider. The program consists of two parts, a premium credit and contributions to your health fund.

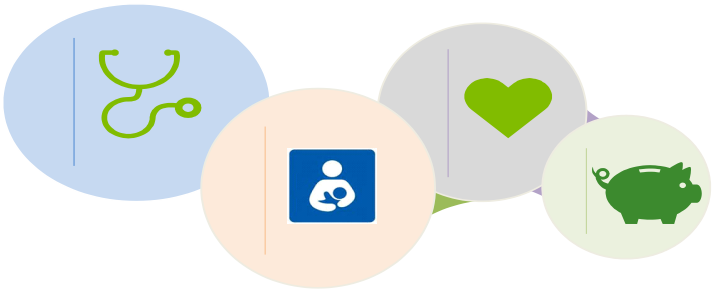
"Premium Credit" – if you are willing to complete HealthAdvocate's online Personal Health Profile (PHP) and an annual biometric screening, you will earn the 2018 premium reduction for your medical coverage. The reduction is $20 per month ($240 a year). Additionally, you may earn program rewards for completing the screening and PHP as well as by participating in various challenges throughout the year.

Biometric Screenings provide vital information about your overall health, including cholesterol, glucose, blood pressure, cardiac risk, Body Mass Index (BMI) and waist measurement. Ciner picks up the cost for the biometric screening.

Employees may visit a lab facility or submit a physician screening form (available on the HealthAdvocate website) if you wish to complete the screenings with your personal physician.

The **Personal Health Profile (PHP)** is a brief survey about specific lifestyle habits. Your completed Personal Wellness Plan will highlight your current risk level for each lifestyle habit and give you tips for improving your overall health.

Complete your biometric screening and your PHP to secure your premium discount as well as begin your path to a healthier you.



Your health plan is committed to help you achieve your best health. Rewards for participating in the wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact HealthAdvocate and they will work with you and your doctor to find a wellness program with the same reward that is right for you in light of your current health status.

UNDERSTANDING
YOUR WELLNESS PROGRAM

Employees enrolled in the Blue or Green Plan can earn up to $750 in their health fund account for completing the activities listed below. Spouses enrolled in the Blue or Green Plan can earn up to $250 for completing the activities.

In order to earn any additional rewards, employees and spouses must each complete the health assessment (gatekeeper). Additionally, employees enrolled in any of the medical plans can earn up to $240 in payroll incentives for completing the health assessment (and biometric screenings) within 30 days of enrollment.

Program Category	Goal Name	Employee Reward HRA/ HSA	Spouse Reward HRA/ HSA	Frequency Goal Dates 1/1/18 — 12/31/18
Personal Health Analysis **THIS GOAL MUST BE COMPLETED BEFORE ANY OTHER INCENTIVES ARE REWARDED**	Get a personalized health assessment. Employees must enter all numbers for payroll credit ($240 max)	$0	$100	Once
Achieve Health Goals Employee Cap: $400 Employees that don't meet the goal, can still earn the incentive if they do any 1 of the following: • Work with a coach to achieve a health goal • Complete an online coaching program • Work with physician on	Achieve a Waist Circumference of less than 41 inches for men; Achieve a Waist Circumference of less than 36 inches for women	$100	NA	Once
	Achieve a healthy cholesterol ratio of less than or equal to 5.0	$100	NA	Once
	Achieve a healthy HDL level of greater than or equal to 40 mg/dl for men; Achieve a healthy HDL level of greater than or equal to 50 mg/dl for women	$100	NA	Once
	Achieve a Fasting Blood Sugar level less than <100 mg/dl *OR* Non-Fasting Blood Sugar level less than 140 mg/dl	$100	NA	Once
	Achieve a healthy blood pressure of 139/89 or less	$100	NA	Once
Preventive Physical	Complete my annual physical (preventive exam)	$100	$100	Once
Other Preventive Care Employee Cap: $200 Spouse Cap: $100	Get a colon cancer screening (preventive exam)	$50	$50	Once
	Get my annual OB/GYN exam (preventive exam)	$50	$50	Once
	Get a cervical cancer screening (preventive exam)	$50	$50	Once
	Get a mammogram (preventive exam)	$50	$50	Once
	Get a flu shot (preventive exam)	$50	$50	Once
	Get a prostate cancer screening (preventive exam)	$50	$50	Once
Personalized Coaching Program	Complete six sessions over a three month period	$400	$50	Once
External Goal	Participate in a 2018 Ciner company wellness challenge	$25	NA	Twice
Self-Reported Activities Employee cap: $200 Spouse cap: $150	Enter your daily healthy activity and achieve the recommended goals— Steps, minutes of exercise, days or resistance training, water intake, sleep, resiliency, charity and resistance training	$1-$10	$1-$10	Daily, Weekly, Monthly
Tobacco Free Commitment	I don't use any tobacco products (e.g. chew, snuff, or cigarette)	$50	NA	Once
Online Coaching Program	Quit Tobacco – Twelve Week Program	$50	NA	Once
Online Coaching Program	Don't Weight—Make A Change— Twelve Week Program	$50	NA	Once

*Frequency Goal Date range only includes period of time during which you are covered under the plan.

UNDERSTANDING
YOUR WELLNESS PROGRAM

Get started today…

The goals of the HealthAdvocate wellness program are to encourage health awareness and health improvement. Employees will be rewarded for:

- Achieving specific health targets
- Completing preventive activities
- Being tobacco-free
- Working with a health coach
- Participating in a Ciner wellness challenge
- Engaging in ongoing health and wellness activities

Employees and spouses enrolled in the Blue Plan or Green Plan can earn up to $750 or up to $250, respectively, in health fund (HRA or HSA) dollars for the completion of health and wellness goals. These dollars will help employees and their families pay for health services, through their health fund account. See the prior page for a full list of goals and their Incentive value. For strategies on how to achieve your full wellness reward, see the employee scenarios below:

Employee Scenario 1:
John Johnson is a relatively healthy employee. He engages in some physical activity and is mindful of his nutrition. He can earn his $750 reward by:

Completed Goals	Incentive Points Earned
Completing a Personal Health Profile	0
Achieving a healthy body mass index	100
Achieving a health total cholesterol level	100
Achieving a health LDL level	100
Though he doesn't achieve a healthy fasting blood sugar level, he completes an online coaching program	100
Completing an annual physical	100
Getting a flu shot	50
Self-reporting that he made smart and delicious food choices - 4 times	100
Self-reporting that he took part in physical activity - 4 times	100
Total Points Earned	**750**

Employee Scenario 2:
Stephanie Stephenson has been diagnosed with high cholesterol. She has been working with her doctor and is making some changes to improve her health. She can earn her $750 reward by:

Completed Goals	Incentive Points Earned
Completing a Personal Health Profile	0
Achieving a healthy body mass index	100
Though she doesn't achieve a healthy total cholesterol level, she works with a wellness coach to achieve a health goal	100
Though she doesn't achieve a healthy LDL level, she works with a wellness coach	100
Achieving a healthy fasting blood sugar level	100
Completing her annual OB/GYN exam	50
Getting a cervical cancer screening	50
Making progress on a health problem	50
Achieving a goal and starting to overcome a health problem - 2 times	100
Self-reporting that she made smart and delicious food choices - 4 times	100
Total Points Earned	**750**

UNDERSTANDING
YOUR HEALTH ADVOCACY PROGRAM

HealthAdvocate

Your Lifeline for Healthcare Help

Top Reasons to Call Us...
866.695.8622

Find the right doctors
We'll also locate the right hospitals, dentists and other leading healthcare providers anywhere in the country.

Schedule appointments
We can help expedite the earliest appointments with providers including hard-to-reach specialists and arrange treatments and tests.

Help resolve insurance claims
Our experts get to the bottom of your issue to assist with negotiating billing and payment arrangements.

Assist with eldercare
We address senior issues such as Medicare and related healthcare issues facing your parents and parents-in-law.

Get cost estimates
You'll receive comparable costs of common medical procedures in your area to help you make informed decisions.

Work with insurance companies
Our team works on your behalf to obtain appropriate approvals for needed services.

Answer questions
We help you become informed about test results, treatments and medications prescribed by your physician.

Assist in the transfer of medical records
We'll also handle the details of transferring X-rays and lab results.

...and much more

Help is Only a Phone Call Away

You will be assigned a Personal Health Advocate. And you, your spouse, dependent children, parents and parents-in-law are eligible to use our service.

866.695.8622 HealthAdvocate.com

HEALTH Advocate™

UNDERSTANDING YOUR DENTAL PLAN

Dental Questions? Need to Locate a Provider?
Contact Delta Dental (Group # 6094)
800-521-2651 or deltadentalins.com

Ciner offers a comprehensive dental plan through Delta Dental. You can elect dental coverage even if you don't elect medical coverage through Ciner.

The plan permits you to use both in-network and out-of-network providers. There are two networks to select from: the Premier and the PPO network. The PPO network providers offer larger discounts and providers in both networks can file your claims for you. If you prefer to see an out-of-network provider, keep in mind, because they are not contracted to accept the negotiated discounted rate, they may charge you for any amount billed in excess of the negotiated discounted rate.

To determine if your dentist is in the network, visit deltadentalins.com, enter your search criteria (location, name, etc.) and select either the Delta Dental PPO or Premier network under the "Find a Dentist" heading.

For specific dental services not identified below or for frequency limitations that may apply, please refer to your Summary of Benefits.

Delta Dental PPO Plan	
Deductible (waived for preventive care)	
Employee Only	$50
Employee plus dependent(s)	$100
Calendar Year Maximum	$1,500
Type of Dental Service	
Preventive Services *-Initial oral exams* *-Periodic oral exams* *-Prophylaxis (cleanings)* *-Topical Application of Fluoride* *-Space maintainers* *-X-rays* *-Sealants*	Covered at 100%*; not subject to Calendar Year Maximum
Basic Restorative Services *-Fillings* *-Endodontics* *-Extractions* *-Repair of dentures* *-Periodontic maintenance cleaning (2 annually)* *-Oral surgery* *-Re-cement crowns/bridge* *-Emergency treatment* *-Relining of dentures*	Plan pays 80%* after Deductible
Major Restorative Services *-Inlays* *-Onlays* *-Post & Core* *-Prosthodontics*	Plan pays 50%* after Deductible
Orthodontic Services	50%* up to $1,500 lifetime maximum per person

*Out-of-network services are reimbursed at the same benefit level up to the maximum allowable charge a network dentist would receive.

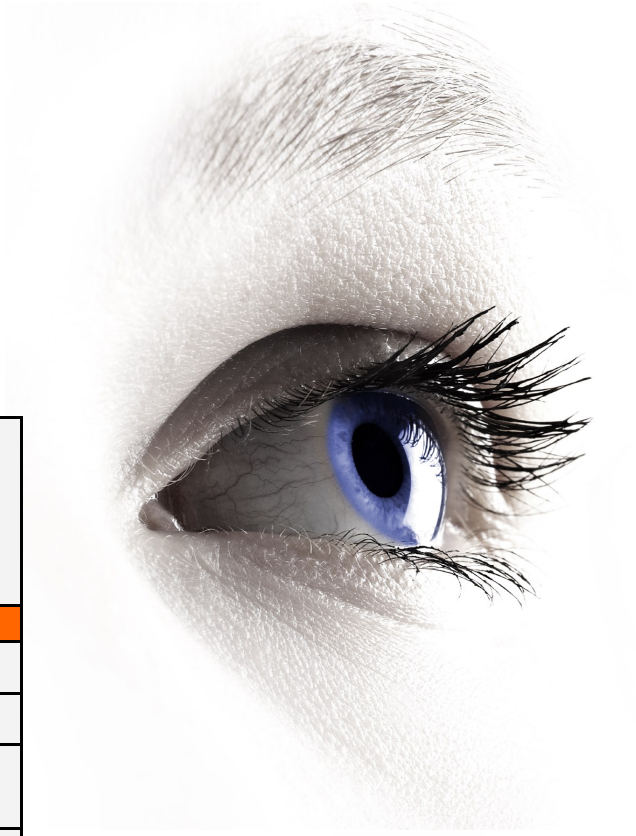
UNDERSTANDING YOUR VISION PLAN

Vision Questions? Need to Locate a Provider?
Contact VSP (Group # 30051568)
800-877-7195 or vsp.com

Ciner offers voluntary vision coverage through VSP.

Ciner provides you and your eligible family members with the opportunity to save on vision care services and products. The VSP vision plan allows you to save on everything from vision exams to contact lenses to eyeglasses. The vision plan gives you two different ways to receive benefits.

- Use the network and pay only a copay for most expenses.
- Go to a provider outside the network and receive a reimbursement for part of the cost of your exams, glasses and contacts when you submit a claim.



Vision	When you use the network… You pay	When you do not use the network… You are reimbursed
Service or Material		
Exams	$10 copay	Up to $45
Eyeglass Lenses	$25 copay	See below
Contact Lens Fitting Evaluation	$60 copay	N/A
Contact Lenses	No copay; $130 allowance	Up to $105
Frames	$25 copay; $130 allowance	Up to $70
Laser Vision Correction	Discount Program	
Lenses		
Single Lenses	Covered in full	Up to $30
Bifocal Lenses	Covered in full	Up to $50
Trifocal Lenses	Covered in full	Up to $65
Contacts (in lieu of glasses)	$130 allowance	Up to $105
Frequency		
Exams	One per 12 months	
Lenses or Contact Lenses	One per 12 months	
Frames	One per 24 months	

Visit vsp.com to access a wealth of information about the importance of eye exams, disease awareness and even how to choose your perfect eyewear.

UNDERSTANDING
YOUR WELFARE BENEFITS

Questions?
Contact Aetna Life Insurance (Group # 0287425)
800-523-5065 or send email to lifequestions@aetna.com

Life and Accidental Death & Dismemberment Insurance - Aetna

Your family depends on your income for a comfortable lifestyle and for the resources necessary to make their dreams - such as a college education - a reality. Like anyone, you don't like to think of the scenario where you're no longer there for your family. However, you do need to ensure their lives and dreams can continue if the worst does happen.

Ciner knows how difficult it can be to provide this peace of mind on your own, which is why we have made it a priority to give you the ability to build a complete life and accidental dismemberment insurance package.

Basic Life Insurance and Accidental Death & Dismemberment Insurance

Your company-paid life and AD&D insurance provides benefits upon your death and/or following any accidental injury which results in a personal loss that is covered under the Plan. While you are automatically enrolled to receive these benefits, you will need to designate a beneficiary during your benefits enrollment process. Your beneficiary will receive the proceeds of the life insurance and/or AD&D policy in the event of your death.

Your benefit is as follows:

Basic Term Life and Accidental Death & Dismemberment (AD&D)	
Amount	1x base earnings, rounded to next $1,000, not to exceed $500,000

If your death is caused in an accident, both your life policy and your AD&D policy may pay benefits to your beneficiary. All life and AD&D benefits are reduced beginning at age 70. Please see your Booklet-Certificate for details.

Supplemental Life and Dependent Life Insurance – Aetna

How much coverage can you buy?

Employees who want to supplement their Basic Life insurance benefits may purchase additional coverage through Aetna. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through after-tax payroll deductions. Spouse rates are based on your age. You can only enroll a spouse and/or dependents if you enroll yourself for supplemental life insurance.

When you are first eligible for coverage (within 30 days of your benefits effective date) you are able to elect up to the guaranteed issue amount for yourself and your dependents without providing Evidence of Insurability. Amounts elected in excess of the guaranteed issue amount or if you want to elect coverage for yourself or your dependents after you are first eligible for coverage, (considered a "late entrant"), you must provide proof of good health and be approved for coverage by the insurance company.

Supplemental Life			
Life Benefit	**Employee**	**Spouse**	**Dependent**
Increments	1-6X salary	$1,000 increments	$1,000 increments
Maximum	$750,000	$50,000	$5,000
Guaranteed Issue	Lesser of 3X or $300,000*	Lesser of 50% of employee amount or $50,000*	$5,000
Evidence of Insurability (EOI)	Required for late entrants and certain benefit increases		

Basic Dependent Life Option
$10,000 Spouse and $5,000 Dependent

Guaranteed issue available for at initial enrollment only

*Age reduction schedule applies. See your Booklet/Certificate for details.

Questions?
Contact Aetna Life Insurance (Group # 0287425)
800-523-5065 or send email to lifequestions@aetna.com

Supplemental Accidental Death and Dismemberment (AD&D) Insurance – Aetna

How much coverage can you buy?

Employees who want to supplement their group accident and death insurance benefits may purchase additional coverage through Aetna. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through payroll deductions. You can only enroll a spouse and/or dependents if you enroll yourself for supplemental AD&D insurance.

AD&D Benefit	Employee	Spouse	Dependent
Increments	$50,000 Increments	70% of Employee AD&D amount with no child coverage; 60% of Employee AD&D amount with child AD&D coverage	20% of Employee AD&D amount with no spouse coverage; 15% of Employee AD&D amount with spouse AD&D coverage
Maximum	Lesser of 10X salary or $500,000	Percentage of Employee AD&D amount	Percentage of Employee AD&D amount

UNDERSTANDING
YOUR WELFARE BENEFITS

Questions?
Contact Aetna Life Insurance (Group # 0287425)
800-523-5065 or aetnadisability.com

Short-Term Disability (STD)

Ciner provides employees with Short-Term Disability coverage at no cost to you. Aetna administers the plan.

STD insurance can provide income when a disability prohibits your ability to work. If you qualify for benefits, you will receive **100% of your base weekly earnings for a period of time that varies based on your length of service and 60% of your base pay for the remaining disability-approved period.** Disability benefit payments **begin on the 4th day of an accident or illness** and continue for the duration of the approved disability but no longer than 26 weeks including the three day waiting period. See the schedule below for additional details.

Any benefits you receive will be considered taxable income.

Long-Term Disability (LTD)

Ciner provides employees with Long-Term Disability coverage at no cost to you through Aetna Life Insurance.

The benefit payable is **60% of your monthly pre-disability earnings up to $13,000 per month**. Disability benefit payments for injuries or illness **begin on the 181st day of an accident or illness** and can continue for the duration of the approved disability up to your Social Security Normal Retirement Age. If you become disabled at age 62 or after, your benefits are payable according to the schedule in your Booklet- Certificate.

During the first 180 days of your disability, you will not receive any benefit payment except as approved through the Short-Term Disability plan. Any benefits you receive will be considered taxable income.

Supplemental Long-Term Disability (LTD)

Ciner employees may purchase additional Long-Term Disability coverage through pre-tax dollars which increases the benefit coverage from 60% to 66 2/3% and the monthly maximum benefit from $13,000 to $15,000.

Any benefits you receive will be considered taxable income.

Short-term disability schedule:

Years of Service	Maximum Duration at 100%	Maximum Duration at 100%
Less than 1 year	0 weeks	26 weeks*
1 year but less than 5 years	7 weeks*	19 weeks
5 years but less than 10 years	13 weeks*	13 weeks
10 years and over	26 weeks*	0 weeks

*includes the 3-day waiting period which is paid at 100%

Evidence of Insurability Process

If you elect life or disability coverages that require proof of good health or Evidence of Insurability (EOI) for your coverage to be approved, your request for coverage will prompt Aetna Life Insurance Company to mail you an EOI packet which contains a web address for you to complete and submit your EOI online. Please follow the instructions to complete your EOI in a timely manner and avoid any delay in benefit approval. Paper EOI forms are still available for those who would prefer to utilize a paper form, they can be found in the Library section of the Ciner Benefit Center website cbizesc.com/ciner. You may also contact the Ciner Benefit Center at 770-375-2300.

HOW DO I FILE AN STD CLAIM?

Questions?
Contact Aetna Life Insurance (Group # 0287425)
800-523-5065 or aetnadisability.com

Aetna offers telephonic claim submission which allows you, or someone on your behalf, to submit a short-term disability claim over the phone. The process should take about 15 minutes.

When to report a claim

- We suggest you call no more than 30 days in advance of a planned medical absence, such as:

  --A prescheduled surgery

  --An expected maternity leave

- Also call if your health care provider has determined you are unable to work because of a non-work-related illness or injury or for maternity reasons.

How to report a claim

1. Notify your manager or supervisor and your HR representative of your absence from work. If you are injured at work, notify your manager or supervisor **as soon as possible**.

2. File your claim by calling the toll-free number below.

4. Once you've created a claim, Aetna will send you a claim intro packet that contains an authorization form. Fill out the authorization form and fax it to Aetna at the fax number below to authorize release of your medical information.

5. Visit your health care provider, and give him or her a copy of the completed authorization form.

Disability Service Center

Short-term disability claims: **866-326-1380**

Fax: **866-667-1987**

Monday – Friday 8 a.m. – 8 p.m. ET

NOTE: Please ensure that you sign the form authorizing Aetna to obtain medical information from your treating provider(s) in order to certify your claim. Failure to do so could result in a delay in the processing of your claim and benefit payments.

Information needed to submit a claim

The following information may be required when you make your claim request. Please have this information ready when you call Aetna. If someone else makes the call on your behalf, he or she will need to provide this information.

Checklist

The following information may be required when you make your claim request:

* Name of your employer
* Health care provider's name, address, fax and phone numbers
* Your name, Social Security number and date of birth
* Your complete address and phone number
* Your occupation (or job title), supervisor's name and phone number
* A brief description of your medical condition, including cause of condition (illness or injury), date of injury or beginning of illness, and whether it is work related
* The dates of your visit(s) with your health care provider for this condition
* Your last day worked and your first day absent from work resulting from this condition
* The date you expect to return to work (if known) or the actual date if you have already returned to work
* Work restrictions or limitations advised by your health care provider, if any

Prompt and complete information from you and your health care provider will help ensure a timely decision and faster payment if you are eligible.

The claim management process

An Aetna benefits specialist will process your claim details and, if necessary, contact Ciner, your physician and you if additional information is needed. You will be notified of any additional steps required to complete the claim review. Once a decision is made, you and Ciner will be notified. You can also track the claim processing progress online at aetnadisability.com.

UNDERSTANDING
YOUR SUPPLEMENTAL BENEFITS

Questions?
Contact AFLAC at 800-433-3036

AFLAC Accident

In the event of a covered accident, the plan pays cash benefits to help with the costs associated with out of pocket expenses and bills—expenses that major medical plans may not take care of, including:

- Ambulance rides
- Wheelchairs, crutches, and other medical appliances
- Emergency room visits
- Surgery and anesthesia
- Bandages, stitches, and casts.

The group accident plan includes added financial resources to help with the cost of follow-up care as well:

- Transportation and Lodging benefits
- Rehabilitation Unit benefits
- Accidental Death and Dismemberment benefits

AFLAC Critical Illness

The plan helps prepare you for the added costs of battling a specific critical illness. With this plan, the goal is to help employees and families cope with and recover from the financial stress of surviving a critical illness. After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered illness. Some of the covered illnesses include:

- Cancer (internal or invasive)
- Heart Attack
- Stroke
- Major organ transplant
- End stage renal failure
- Carcinoma in situ (25% of benefit amount)
- Coronary artery bypass surgery (25% of benefit amount)

Additional lump sum benefits are payable for a reoccurrence of critical illness or a diagnosis of a second critical illness.

AFLAC Hospital Indemnity

The Supplemental Hospital Indemnity plan offers employees and eligible dependents a solution to the financial burdens created by unexpected trips to the physician's office or hospital emergency room. This plan provides additional protection against unplanned expenses due to serious injury or illness. Various lump sum payments will be paid for an assortment of medical procedures and situations such as:

- Hospital Confinement (per day up to 180 days)
- Hospital Admission (per admission)
- Intensive Care (per day up to 30 days)
- Surgical Benefit (per procedure)
- Anesthesia
- Hospital Emergency Room (per visit)

Legal Shield

The plan gives you the ability to talk to an attorney 24/7 on any personal legal issue. Services include:

- Advice on an unlimited number of topics
- Letters and phone calls on your behalf
- Legal document review
- Will preparation
- Trial defense hours

Identity Theft

The Identity Theft plan gives you access to three credit reports as well as continuous monitoring of your credit. Restoration services are also available. In addition, the Identity Theft plan includes daily web monitoring for unauthorized use of your personal information, lost ID assistance, and credit safeguarding for minor children.

Employees can elect individual coverage, family coverage, or waive coverage. Employees do not have to elect the same level of coverage for both Legal Shield and Identity Theft—the only limitation is that employees cannot elect the Individual Legal Plan and the Family Identity Theft plan.

UNDERSTANDING YOUR EAP PROGRAM

Contact Magellan
800-523-5668 or MagellanHealth.com/member

Magellan—Employee Assistance Program (EAP)

It's All About Balance

We know that living a productive and fulfilling life requires a healthy mind and a healthy body. Unfortunately, managing the daily stresses of work, home and family can have a negative effect on our overall health and well-being. For many of us, life is quite simply "out of balance," leaving us feeling overwhelmed and stressed-out. Your EAP program can help.

Some stress can motivate us to achieve things we never thought possible. But too much stress over a long period of time can cause us to do things we normally wouldn't do. It can negatively affect personal and professional relationships, make us feel overwhelmed, lose hope and can lead to more serious issues, including depression, anxiety and substance abuse.

A Wealth of Practical, Solution-Focused Resources

Your EAP program has the resources and the experience to help you bring things back into balance.

From online resources to confidential telephonic consultations to referrals and licensed behavioral health professionals, we're here to help you make the changes necessary to reduce stress, strengthen relationships, increase productivity and improve the overall quality of life.

Here are just a few of the challenges where your program can help:

- Managing stress
- Handling relationship issues
- Balancing work and life
- Quitting tobacco, alcohol or drug use
- Caring for children or aging parents
- Exploring career development options
- Dealing with conflict or violence
- Working through grief and loss issues
- Controlling depression and anxiety

Living Healthy Working Well

Living your healthiest, most productive and fulfilling life is within your control. We're here to provide the support and the resources to help you live life-better! Click or call now, and you're on your way to living the life you want to live.

Through your Magellan program, you also have access to the following:

- Qualified child and elder care referrals
- Adoption information and resources
- Legal consultation
- Financial services consultation
- New Parent return-to work support

One toll-free number provides assistance for:

Child and Elder Care Services

- A trained child and elder care program consultant.
- Listings of providers and resources in your area.
- Immediate clinical support if necessary.
- Child and elder care referral and information on MagellanHealth.com/member

Legal Consultation Services

- One free office or telephone consultation with an attorney in your state for each new legal matter.
- Consultation on a wide range of issues from civil to criminal matters, family and divorce law, real estate, wills, estate planning and more.
- Additional legal services at a 25 percent discount.

New Parent Coaching Program

To get started with a New Parent Coach, email ParentRTWSupportProg@MagellanHealth.com.. Include your name, company, telephone number and the best time to reach you. A New Parent Coach will contact you to offer:

- A comprehensive needs assessment for new parents.
- Ongoing consultations to help you smoothly transition into working parenthood.

Life Management Resources & Referrals

A full range of parenting, adoption, education and child and elder care resources, including:

- Online referral and information services via MagellanHealth.com/member.
- A program consultant available through your program's toll-free number.
- Listing of pre-screened, qualified referrals to providers and other resources in your area.

Financial Consultation Services

- Consultation on a wide range of financial issues such as budgeting, debt consolidation, retirement, saving for college and more.
- Unlimited number of free 60 minute telephonic consultations and/or a free initial in-person consultation, depending upon your issue.

2018 EMPLOYEE CONTRIBUTIONS

Medical Coverage	Semi-Monthly	Bi-Weekly	Monthly
Blue Plan*			
Employee	$84.55	$78.05	$169.10
Employee + spouse^	$203.62	$187.95	$407.23
Employee + child(ren)	$185.00	$170.77	$370.00
Employee, spouse + child(ren)^	$302.71	$279.42	$605.42
Green Plan*			
Employee	$54.63	$50.43	$109.26
Employee + spouse^	$127.47	$117.66	$254.94
Employee + child(ren)	$115.33	$106.46	$230.66
Employee, spouse + child(ren)^	$188.17	$173.70	$376.34
White Plan*			
Employee	$41.86	$38.64	$83.71
Employee + spouse^	$97.78	$90.25	$195.55
Employee + child(ren)	$88.47	$81.66	$176.93
Employee, spouse + child(ren)^	$144.34	$133.23	$288.67

**Contributions shown do NOT include Premium Credit (wellness discount) - complete online Personal Health Profile and annual biometric screening and save $20 per month (up to $240 annually) in payroll contributions for 2017.*

^Above medical contributions do NOT include any applicable Spousal Surcharge ($100 per month).

Dental Coverage	Semi-Monthly	Bi-Weekly	Monthly
Employee	$4.56	$4.20	$9.11
Employee + spouse	$9.11	$8.41	$18.22
Employee + child(ren)	$10.02	$9.25	$20.04
Employee, spouse + child(ren)	$14.58	$13.45	$29.15

Vision Coverage	Semi-Monthly	Bi-Weekly	Monthly
Employee	$5.15	$4.75	$10.29
Employee + spouse	$8.24	$7.60	$16.47
Employee + child(ren)	$8.41	$7.76	$16.81
Employee, spouse + child(ren)	$13.55	$12.51	$27.10

***Please note**: Medical, vision, dental, AD&D, and long term disability contributions are paid with pre-tax dollars. Annual Base Salary for hourly employees is the employee's standard hourly rate multiplied by 2080. It excludes overtime and any other compensation. Actual payroll deductions may be slightly different due to rounding.*

2018 EMPLOYEE CONTRIBUTIONS

Supplemental Employee, Spouse and Dependent Life Insurance

Employee/Spouse Rates
based on employee age
as of 1/1/2018:

	Rates		
	Semi-Monthly	Bi-Weekly	Monthly
<25	$0.037	$0.034	$0.073
25-29	$0.042	$0.039	$0.084
30-34	$0.056	$0.052	$0.112
35-39	$0.063	$0.058	$0.126
40-44	$0.070	$0.065	$0.140
45-49	$0.107	$0.098	$0.213
50-54	$0.161	$0.149	$0.322
55-59	$0.301	$0.278	$0.602
60-64	$0.462	$0.426	$0.924
65-69	$0.889	$0.821	$1.778
70+	$1.442	$1.331	$2.884
Child	$0.090	$0.083	$0.180
Family Unit	$1.000	$0.923	$2.000
Employee Only AD&D	$0.018	$0.016	$0.035
Family AD&D	$0.030	$0.028	$0.060

($1,000 increments up to $5,000 max - covers each child for elected amount)

($10,000 Spouse and $5,000 Child(ren) - flat rate regardless of number of individuals covered)

Deduction per pay period (**Employee Life coverage**) = Annual Base Salary rounded to next highest $1,000/$1,000 times elected increment of salary (1-6X) times illustrated rate by age band by pay frequency

Deduction per pay period (**Spouse Life coverage**) = Elected amount/$1,000 times illustrated rate by age (based on employee's age) band by pay frequency

Deduction per pay period (**AD&D**) = Elected amount in $50,000 increments/$1,000 times illustrated rate by family tier by pay frequency

Supplemental Long-Term Disability Insurance

Employee Only	$0.125	$0.115	$0.250

(Increases benefit payable from 60% to 66.67% of pre-disability earnings)

Deduction per pay period (**LTD Buy-Up**) = Annual Base Salary/12/$100 times illustrated rate by pay frequency

NOTE: Medical, dental, vision and supplemental long-term disability contributions are made pre-tax. Annual Base Salary for hourly employees is the employee's standard hourly rate multiplied by 2080. It excludes over-time and any other compensation. Actual payroll deductions may vary slightly due to rounding.

2018 EMPLOYEE CONTRIBUTIONS

All Rates are shown Semi-Monthly

AFLAC - Critical Illness Employee Rates - NON TOBACCO										
Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.23	$3.62	$4.98	$6.37	$7.74	$9.12	$10.49	$11.87	$13.24	$14.63
30-39	$3.10	$5.31	$7.54	$9.77	$11.98	$14.21	$16.45	$18.68	$20.89	$23.12
40-49	$5.55	$10.23	$14.89	$19.57	$24.25	$28.93	$33.58	$38.26	$42.94	$47.62
50-59	$8.71	$16.53	$24.38	$32.20	$40.04	$47.86	$55.71	$63.53	$71.37	$79.19
60-69	$13.37	$25.87	$38.37	$50.87	$63.38	$75.88	$88.36	$100.86	$113.36	$125.86

AFLAC - Critical Illness Spouse Rates - NON TOBACCO									
Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.23	$2.93	$3.62	$4.31	$4.98	$5.68	$6.37	$7.06	$7.74
30-39	$3.10	$4.20	$5.31	$6.44	$7.54	$8.65	$9.77	$10.88	$11.98
40-49	$5.55	$7.89	$10.23	$12.55	$14.89	$17.23	$19.57	$21.91	$24.25
50-59	$8.71	$12.61	$16.53	$20.45	$24.38	$28.28	$32.20	$36.12	$40.04
60-69	$13.37	$19.61	$25.87	$32.11	$38.37	$44.61	$50.87	$57.11	$63.38

AFLAC - Critical Illness Employee Rates - TOBACCO										
Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$3.03	$5.22	$7.39	$9.58	$11.74	$13.91	$16.10	$18.27	$20.43	$22.62
30-39	$4.59	$8.32	$12.05	$15.77	$19.50	$23.23	$26.93	$30.66	$34.39	$38.11
40-49	$10.51	$20.17	$29.81	$39.48	$49.12	$58.76	$68.42	$78.07	$87.71	$97.37
50-59	$16.32	$31.76	$47.21	$62.66	$78.11	$93.56	$109.03	$124.48	$139.92	$155.37
60-69	$25.55	$50.22	$74.90	$99.56	$124.24	$148.92	$173.59	$198.27	$222.95	$247.61

AFLAC - Critical Illness Spouse Rates - TOBACCO									
Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$3.03	$4.14	$5.22	$6.31	$7.39	$8.47	$9.58	$10.66	$11.74
30-39	$4.59	$6.46	$8.32	$10.18	$12.05	$13.91	$15.77	$17.64	$19.50
40-49	$10.51	$15.34	$20.17	$24.98	$29.81	$34.65	$39.48	$44.29	$49.12
50-59	$16.32	$24.05	$31.76	$39.50	$47.21	$54.95	$62.66	$70.40	$78.11
60-69	$25.55	$37.87	$50.22	$62.55	$74.90	$87.23	$99.56	$111.91	$124.24

AFLAC - Accident	
Employee	$7.58
Employee + spouse	$12.37
Employee + child(ren)	$14.86
Employee, spouse + child(ren)	$19.65

AFLAC - Hospital Indemnity	
Employee	$30.00
Employee + spouse	$59.61
Employee + child(ren)	$44.67
Employee, spouse + child(ren)	$74.28

Legal / Identity Theft	Employee	Family
Legal Plan Only	$8.48	$9.48
Identity Theft Plan	$4.48	$9.48
With Legal Plan	$12.95	$16.95

2018 EMPLOYEE CONTRIBUTIONS

All Rates are shown Bi-Weekly

AFLAC - Critical Illness
Employee Rates - NON TOBACCO

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.06	$3.34	$4.60	$5.88	$7.14	$8.42	$9.68	$10.96	$12.22	$13.50
30-39	$2.86	$4.90	$6.96	$9.02	$11.06	$13.12	$15.18	$17.24	$19.28	$21.34
40-49	$5.12	$9.44	$13.74	$18.06	$22.38	$26.70	$31.00	$35.32	$39.64	$43.96
50-59	$8.04	$15.26	$22.50	$29.72	$36.96	$44.18	$51.42	$58.64	$65.88	$73.10
60-69	$12.34	$23.88	$35.42	$46.96	$58.50	$70.04	$81.56	$93.10	$104.64	$116.18

AFLAC - Critical Illness
Spouse Rates - NON TOBACCO

Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.06	$2.70	$3.34	$3.98	$4.60	$5.24	$5.88	$6.52	$7.14
30-39	$2.86	$3.88	$4.90	$5.94	$6.96	$7.98	$9.02	$10.04	$11.06
40-49	$5.12	$7.28	$9.44	$11.58	$13.74	$15.90	$18.06	$20.22	$22.38
50-59	$8.04	$11.64	$15.26	$18.88	$22.50	$26.10	$29.72	$33.34	$36.96
60-69	$12.34	$18.10	$23.88	$29.64	$35.42	$41.18	$46.96	$52.72	$58.50

AFLAC - Critical Illness
Employee Rates - TOBACCO

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$2.80	$4.82	$6.82	$8.84	$10.84	$12.84	$14.86	$16.86	$18.86	$20.88
30-39	$4.24	$7.68	$11.12	$14.56	$18.00	$21.44	$24.86	$28.30	$31.74	$35.18
40-49	$9.70	$18.62	$27.52	$36.44	$45.34	$54.24	$63.16	$72.06	$80.96	$89.88
50-59	$15.06	$29.32	$43.58	$57.84	$72.10	$86.36	$100.64	$114.90	$129.16	$143.42
60-69	$23.58	$46.36	$69.14	$91.90	$114.68	$137.46	$160.24	$183.02	$205.80	$228.56

AFLAC - Critical Illness
Spouse Rates - TOBACCO

Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.80	$3.82	$4.82	$5.82	$6.82	$7.82	$8.84	$9.84	$10.84
30-39	$4.24	$5.96	$7.68	$9.40	$11.12	$12.84	$14.56	$16.28	$18.00
40-49	$9.70	$14.16	$18.62	$23.06	$27.52	$31.98	$36.44	$40.88	$45.34
50-59	$15.06	$22.20	$29.32	$36.46	$43.58	$50.72	$57.84	$64.98	$72.10
60-69	$23.58	$34.96	$46.36	$57.74	$69.14	$80.52	$91.90	$103.30	$114.68

AFLAC - Accident

Employee	$7.00
Employee + spouse	$11.42
Employee + child(ren)	$13.72
Employee, spouse + child(ren)	$18.14

AFLAC - Hospital Indemnity
(rates show per pay period)

Employee	$27.69
Employee + spouse	$55.02
Employee + child(ren)	$41.23
Employee, spouse + child(ren)	$68.56

Legal / Identity Theft

	Individual	Family
Legal Plan Only	$7.82	$8.75
ID Theft Plan (3 Credit Bureaus)	$4.13	$8.75
With Legal Plan	$11.95	$15.65

CONTACTS

Find policy numbers, customer service phone numbers and website for your benefit providers below.			
BENEFIT	**CARRIER NAME and ID NUMBER**	**PHONE NUMBER**	**WEBSITE**
Connect to any of Ciner's carriers - single point of contact	Health Advocate Gateway	866.799.2731	healthadvocate.com
Medical Plan Administrator	Continental Benefits CB360	855.347.2638	continentalbenefits.com
Medical Network	Aetna Aetna Signature Administrators		asalookup.aetnasignature administrators.com or call HealthAdvocate Gateway
Medical Pre-certification	HealthCare Strategies	800.585.1535	continentalbenefits.com
Pharmacy Benefits	WellDyneRx CB360	888.479.2000	welldynerx.com
Dental	Delta Dental 6094	800.521.2651	deltadentalins.com
Vision	VSP 30051568	800.877.7195	vsp.com
Life/AD&D **Supplemental Life/AD&D** **STD** **LTD**	Aetna Life Insurance Company 0287425	800.523.5065	aetna.com aetnadisability.com
Flexible Spending Accounts **Health Reimbursement Account** **Health Savings Account**	Discovery Benefits	866.451.3399	discoverybenefits.com
Employee Assistance Program	Magellan	800.523.5668	magellanhealth.com/ member
Wellness Program & Advocacy Benefits (personal assistance with wellness program, benefit or coverage questions, claims concerns, network provider location services and more)	Health Advocate	866.799.2731	healthadvocate.com/ciner
401(k) Plan	Merrill Lynch	800.229.9040	benefits.ml.com
Ciner Benefits Department		770.375.2300 option 6 benefits@ciner.us.com	cbizesc.com/ciner

2018 Health Plan Notices

Women's Health and Cancer Rights Act of 1998

Your medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema).

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The law prevents discrimination from health insurers and employers.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

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

This Notice is being distributed in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security rules which are intended to protect certain personally identifiable health information without disrupting the timeliness or quality of medical care. As used in this Notice, "health information" means your protected health information or "PHI." PHI is information, including demographic information, that may identify you and that relates to health care services provided to you, payment for health care services provided to you, or your physical or mental health or condition, in the past, present or future.

As a member of the Ciner Health Plan, we want to assure you that we recognize our obligation to keep your PHI secure and confidential. This Notice applies to your health, prescription drug, dental, flexible spending account, and employee assistance program benefits (The Plans). This Notice explains our privacy practices and it should answer questions about how we safeguard your PHI. Regardless of whether you are an employee, retiree or dependent, we are committed to protecting and maintaining the privacy of any PHI in our possession.

COLLECTION AND USE OF INFORMATION

We may collect PHI about you in connection with your plan enrollment or application for claim payment. This information will be used by authorized company personnel solely for these purposes. For example, the Plans collect the following types of information in order to provide benefits:

- Information that you provide to enroll in the Plans, including personal information such as your address, telephone number, date of birth, and Social Security number.

- Plan contributions and account balance information.

- The fact that you are or have been enrolled in the Plans.

- Health-related information received from any of your physicians or other healthcare providers.

- Information regarding your health status, including diagnosis and claims payment information.

- Changes in Plan enrollment (*e.g.*, adding or dropping a participant, adding or dropping a benefit).

- Payment of Plan benefits.

- Claims adjudication.

- Case or medical management.

- Other information about you that is necessary for us to provide you with health benefits.

GROUP HEALTH PLAN RESPONSIBILITIES

The Plans are required to:

- Maintain the privacy of your PHI.

- Provide you with this Notice as to the Plans' legal duties and privacy practices with respect to information that is collected and maintained about you.

- Notify you of a breach of your unsecured PHI.

- Abide by the terms of this Notice.

DISCLOSURE OF INFORMATION

The Plans may use or disclose your PHI without your authorization for purposes of treatment, payment, or healthcare operations:

- *Treatment*. Treatment refers to the provision and coordination of health care by a doctor, hospital, or other health care provider. For example, the Plans may disclose your PHI to your doctor, at the doctor's request, for your treatment by him or her. The Plans themselves do not provide treatment.

- *Payment*. Payment refers to the activities of the Plans in collecting contributions and paying claims for health care services you receive. For example, the Plans may use or disclose your PHI to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment. Other examples include sending your PHI to an external medical review company to determine the medical necessity or experimental status of a treatment; sharing PHI with other payors (such as insurance companies) to determine coordination of benefits or settle subrogation claims; and providing PHI to the pertinent Plan's third party administrators for pre-certification or case management services.

- *Health Care Operations*. Health Care Operations refers to the basic business functions necessary to operate the Plans. For example, the Plans may use or disclose your PHI (i) to conduct quality assessment and improvement activities, (ii) for underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a contract of health insurance, (iii) to authorize business associates to perform data aggregation services, (iv) to engage in care coordination or case management, and (v) to manage, plan, or develop one of the Plans' business operations.

In addition, the Plans may use and disclose your PHI in the following ways:

- To you, as the covered individual.

- To a personal representative designated by you to receive PHI or a personal representative designated by law such as the parent or legal guardian of child, or the surviving family members or representative of the estate of a deceased individual.

- In providing you with information about treatment alternatives and other benefits and services that may be of interest to you as a result of a specific condition that a Plan is case managing.

- To the Secretary of Health and Human Services ("HHS") or any employee of HHS as part of an investigation to determine our compliance with the medical privacy rules, or as otherwise required by federal, state, or local law.

- To a "business associate" that performs services for the pertinent Plan. Each business associate must agree in writing to ensure the continuing confidentiality and security of your PHI.

- To the Plan Sponsor, under these circumstances: (i) Each Plan may disclose, in summary form, claims history and other similar information that does not disclose your name or other distinguishing characteristics. (ii) Each Plan may disclose the fact that you are enrolled in, or dis-enrolled from, the Plan. (iii) Each Plan may disclose your PHI to the Plan Sponsor for Plan administrative functions if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your PHI. The Plan Sponsor also must agree not to use or disclose your PHI for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor.

- To a "health oversight agency" such as the U.S. Department of Labor or the Internal Revenue Service to respond to inquiries or investigations of the Plans, or requests to audit the Plans to federal officials for lawful intelligence, counterintelligence, and other national security purposes; to public health authorities for public health purposes; and to appropriate military authorities, if you are a member of the armed forces.

- In response to a court order, subpoena, discovery request, or other lawful judicial or administrative proceeding.

- To a governmental authority, including a social service or protective services agency, in limited circumstances when an individual is reasonably believed to be a victim of abuse, neglect, or domestic violence.

- As required for limited law enforcement purposes or to avert a serious threat to an individual's or the public's health or safety (for example, to notify authorities of a criminal act).

- As required to comply with Workers' Compensation or other similar programs established by law.

- For research purposes in limited circumstances.

- To a coroner, medical examiner, or funeral director about a deceased person.

- To an organ procurement organization in limited circumstances.

- The Plans may disclose PHI in the event of a transfer of assets from a Plan to another plan or merger of a Plan with another plan (generally in the context of a business transaction of the Plan Sponsor) and for related due diligence.

- To a school if the PHI disclosed is limited to proof of immunization and the school is required by State or other law to obtain proof of immunization.

Uses and Disclosures That Require Your Written Authorization

None of the Plans will use or disclose your PHI for any other purposes except those listed above unless you give the applicable Plan your written authorization. Some uses and disclosures that require your written authorization include:

- Sales and Marketing of PHI. The Plans may not sell or market your PHI without your written authorization. The Plans do not sell, rent, or license your PHI. Your PHI is not marketed to anyone (for this purpose, marketing means communications that encourage you to purchase or use a product or service). Certain communications are not treated as marketing and do not require your authorization, including face-to-face communications made by the Plans to you and promotional gifts of nominal value provided by the Plans.

- Psychotherapy Notes. The Plans and health care providers may not use or disclose psychotherapy notes without your written authorization except for limited purposes, such as carrying out treatment, payment, or health care operations. The Plans do not maintain or have access to psychotherapy notes.

If you give a Plan written authorization to use or disclose your medical information for a purpose that is not described in this Notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all of your PHI that the Plan maintains, to the extent that the Plan has not already used or disclosed PHI in reliance on your authorization.

Genetic Information

Your genetic information is treated as PHI and is subject to special protections. The Plans are not permitted to use or disclose your genetic information for underwriting purposes, which includes (i) determining whether you are eligible for benefits; (ii) determining the premium for coverage; (iii) determining whether you are subject to a pre-existing condition exclusion (if any); and (iv) other activities related to the creation, renewal, or replacement of the coverage provided by the Plan. "Genetic information" includes genetic tests of an individual or family member, family medical histories, and genetic services (for example, counseling, education, and evaluation of genetic information). Family members include dependents, immediate family members, and extended family members, up to the fourth degree of kinship (great, great grandparents; great, great grandchildren; and children of first cousins).

For purposes of protecting your genetic information, any reference to an individual or family member also includes a fetus carried by an individual or family members and an embryo legally held by an individual or a family member utilizing an assisted reproductive technology.

Other Health Information

Not all health information relating to you is PHI subject to these rules. The use and disclosure of health information that you provide (or that is provided by someone else at your request) and is received and maintained by your employer as part of your employment records is not subject to these rules. Your employer may use such information to fulfill its legal obligations under the Family and Medical Leave Act, the Americans with Disabilities Act, or to disclose such health information in connection with the provision to you (or your beneficiaries) of life insurance, disability, or workers' compensation benefits.

Your Rights Regarding Your Medical Information (PHI)

You have the right to request that a Plan do one or more of the following concerning your PHI:

- To put additional restrictions on the Plan's use and disclosure of your PHI. The Plan does not have to agree to your request, unless your request is to restrict the use or disclosure of PHI for payment or healthcare operations for which you have made payment in full (out-of-pocket) for the services.

- To communicate with you in confidence about your PHI by a different means or at a different location than the Plan is currently doing. The Plan does not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plan to collect contributions and pay claims. Your request must specify the alternative means or location to communicate with you in confidence.

- To see and get copies of your PHI that is contained in a designated record set for as long as the Plan maintains the PHI. A "designated record set" contains claim information, payment, and billing records and any other records the Plan has created in making claim and coverage decisions relating to you. If your PHI is maintained electronically, then you may request the PHI in electronic form. You may not have access to the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed.

- To correct your PHI in a designated record set, for as long as the Plan maintains the PHI. The Plan may deny your request if it determines that the medical information was not created by the Plan, is not part of designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If the Plan denies your request, you have the right to include a statement of disagreement with your PHI, and the Plan has a right to include a rebuttal to your statement, a copy of which will be provided to you.

- To receive a list of disclosures of your PHI that the Plan and its business associates for certain purposes (not including disclosures for treatment, payment, and health care operations, as described above, and disclosures made to you or your personal representative) for the last 6 years. If you request more than one accounting within a 12-month period, the Plans may charge a reasonable, cost-based fee for each subsequent accounting.

- To send you a paper copy of this Notice if you received this notice by e-mail or on the internet, even if you previously agreed to accept this Notice electronically.

- To exercise any of these rights described in this Notice, please contact the Ciner Benefits Committee. The Committee will give you the necessary information and forms for you to complete and return. In some cases, the Plan may charge you a nominal, cost-based fee to carry out your request.

Notice of Breach

The Plans must notify you of a breach of your unsecured PHI. In general, a breach occurs if an unauthorized acquisition, access, use, or disclosure of PHI compromises the security or privacy of such information. The Plans have implemented policies and procedures to comply with the HIPAA Privacy and Security requirements and the breach notification requirements, including risk assessment standards to determine when the security or privacy of unsecured PHI has been compromised.

Complaints

If you believe your privacy rights under HIPAA have been violated, or if you believe that your employer has violated the policies adopted by the Plan Sponsor for the protection of your rights, you may file a complaint with the Ciner Benefits Committee listed below. Upon your request, the Committee will provide to you a complete copy of the Plan's complaint procedure and the form (if any) necessary to file a complaint. Neither the Plan nor the Plan Sponsor will retaliate against you for filing a complaint. You may also file a complaint at any time with the U.S. Department of Health and Human Services ("DHHS"). Please go to the DHHS website (http://www.dhhs.gov) for information about how to file a complaint.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the Ciner Benefits Committee, 5 Concourse Parkway, Suite 2500, Atlanta, GA 30328, 770-375-2320.

This Notice was first published and originally became effective on April 14, 2003. This Notice was last updated effective November 1, 2017. Please note that changes in law affecting your privacy rights may take effect at different times.

Important Notice from Ciner About

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ciner and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Ciner has determined that the prescription drug coverage offered through WellDyne is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Ciner coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Ciner coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Ciner and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes through Ciner. You also may request a copy of this notice at any time.

Name of Entity/Sender:	Ciner Resources Corporation
Contact--Position/Office:	Ciner Benefits Committee
Address:	Five Concourse Parkway, Suite 2500, Atlanta, GA 30328
Phone Number:	770-375-2300

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law took effect in 2014, another way to buy health insurance was introduced: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins each year in October for coverage starting as early as the next following January.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.66% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Ciner Benefits Committee.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Ciner Resources Corporation		4. Employer Identification Number (EIN) 06-1446396
5. Employer address 5 Concourse Parkway Suite 2500		6. Employer phone number 770-375-2300
7. City Atlanta	8. State GA	9. ZIP code 30328
10. Who can we contact about employee health coverage at this job? Ciner Benefits Committee		
11. Phone number (if different from above) 770-375-2300	12. Email address benefits@ciner.us.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

All active full-time employees and part-time regular employees working 30 or more hours per week. Temporary employees, seasonal employees, co-ops, and individuals who work less than 30 hours a week on average are not eligible for coverage.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Your lawful spouse (not your legally separated, divorced or common-law spouse). Your children to age 26 which include your biological children, your legally adopted children, your stepchildren who live with you, and children for whom you are the legal guardian. Unmarried children of any age who are incapable of self-sustaining employment

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Ciner Wyoming Holding Co		4. Employer Identification Number (EIN) 22-3151771
5. Employer address 254 County Road 4-6		6. Employer phone number 307-872-7496
7. City Green River	8. State WY	9. ZIP code 82935
10. Who can we contact about employee health coverage at this job? Your local Human Resources Representative of the Ciner Benefits Committee		
11. Phone number (if different from above) 770-375-2300	12. Email address benefits@ciner.us.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

All active full-time employees and part-time regular employees working 30 or more hours per week. Temporary employees, seasonal employees, co-ops, and individuals who work less than 30 hours a week on average are not eligible for coverage.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Your lawful spouse (not your legally separated, divorced or common-law spouse). Your children to age 26 which include your biological children, your legally adopted children, your stepchildren who live with you, and children for whom you are the legal guardian. Unmarried children of any age who are incapable of self-sustaining employment

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are an active employee declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends and you fulfill other special enrollment requirements. (These requirements are set out in your Certificate of Coverage)

In addition, if active employees have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

There is an additional enrollment period if an active employee or dependent loses eligibility for Children's Health Insurance Program (CHIP), Medicaid or becomes eligible for CHIP for Medicaid premium assistance. The special enrollment allows children or their parents to have 60 days, rather than 30, to request enrollment.

Also, your health plan may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor.

Notes

Disclaimer: This Benefit Guide provides a brief summary of the benefits available under the Ciner Benefit Program. In the event of any discrepancy(ies) between this summary and any Document, Insurance Contract or Certificate, the Insurance Document(s) will prevail. Ciner retains the right to modify or eliminate these benefits at any time and for any reason.