ALBEMARLE CORPORATION

HEALTH REIMBURSEMENT ARRANGEMENT

PLAN FOR RETIREES

Summary Plan Description

January 1, 2016

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INTRODUCTION

Under the Albemarle Health Reimbursement Arrangement Plan for Retirees (the "Plan") you may choose to participate in the benefits outlined in this Summary Plan Description ("SPD"). This SPD will also tell you about other important information concerning the Plan.

Under the Plan, Albemarle offers the opportunity for qualifying retired employees to enroll in this Plan for purposes of establishing an individual Health Reimbursement Arrangement ("Account") to receive a reimbursement for eligible insurance premium costs incurred in connection with selecting and purchasing individual medical and prescription drug plans on the Mercer Marketplace exchange for Eligible Retirees, as described in more detail in this SPD. The funds contributed to each individual Account come from Albemarle's general assets. Participants have no obligation to fund their Accounts and the amounts reimbursed to Participants should be excludable from their taxable income.

Albemarle is the Plan Administrator under the Plan and is responsible for the administration of the Plan. As Plan Administrator, its duties are to exercise supervisory control over the Plan's operation, including determination of who is a Participant in the Plan and Plan Participants' eligibility to receive benefits. Additionally, the Plan Administrator has full discretionary authority to interpret and administer, in its sole discretion, the terms of the Plan and to make binding factual determinations. These duties may be delegated to the appropriate parties including Albemarle's employees.

This booklet, which also serves as the Plan document for the Plan, describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. Anyone covered under the Plan should not rely on any oral description of the Plan because written terms of the Plan will always govern if there is a conflict.

Definitions

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

Account. The recordkeeping account otherwise referred to as the Health Reimbursement Arrangement that is established and maintained in the name of a Participant, which includes the amounts contributed by Albemarle to reimburse Participants for eligible insurance premiums.

Albemarle. Albemarle Corporation, the sponsor of this Plan.

Benefits. The reimbursement benefits that are in your Account, as are contributed by Albemarle, to cover the costs of insurance coverage purchased through the Mercer Marketplace.

Code. The Internal Revenue Code of 1986, as amended from time to time.

Eligible Retiree. A former Albemarle employee who, as of their retirement date, has completed at least 10 years of service and has attained the age of 55. This definition does not include an active in-service employee of Albemarle or any other employer in which the employee receives a form of compensation from the employer, any individual employed by an employer at a location outside the United States, an independent contractor, or self-employed individuals. Whether an individual qualifies as an Eligible Retiree will be determined solely in Albemarle's discretion.

Employer. Albemarle Corp. or its successors, and any other associated entity that participates in the Plan with the approval of Albemarle.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

HIPAA. The Health Insurance Portability and Accountability Act of 1996, as amended.

HRA. Health reimbursement arrangement.

Plan. The Albemarle Health Reimbursement Arrangement Plan for Retirees, as amended or restated from time to time.

Participant. An Eligible Retiree who has completed an enrollment form, and has selected and purchased insurance coverage on the Mercer Marketplace, no later than December 31 in the Plan Year before coverage begins (or within 30 days after becoming an Eligible Retiree, if later), and has not ceased, suspended, or become an ineligible Participant in the Plan.

Plan Administrator. The administrator of this Plan is Albemarle.

Plan Year. The 12-month period commencing on January 1st and ending on December 31.

PART I

GENERAL INFORMATION ABOUT THE PLAN

1. How does the Plan work?

Separate from this Plan, Mercer Marketplace offers health related insurance plans to Eligible Retirees of Albemarle (referred to in this SPD as the "Mercer Plans"). You should review the separate materials you have been provided that describe these various plans. Before the beginning of each Plan Year, during the time designated by Albemarle, Eligible Retirees will have the opportunity to select and purchase an insurance plan made available on the Mercer Marketplace for individual medical and prescription drug coverage.

Under this HRA Plan, Albemarle will create and maintain an individual Account for you if you are an Eligible Retiree who has timely enrolled in one of the Mercer Plans. Each Account will contain funds contributed by Albemarle on a monthly basis to reimburse you for your monthly insurance premium costs incurred, subject to the applicable reimbursement rules below for retirees who are ineligible for Medicare, Medicare Supplement or Medicare Advantage. These funds come from Albemarle's general assets and you have no funding obligation with respect to your Account.

(a) *Non-Medicare Eligible Retirees*: If you are an Eligible Retiree but have not yet enrolled in Medicare, you are eligible for a $750 monthly contribution to your Account. To receive these contributions, Non-Medicare Eligible Retirees must follow the reimbursement claims procedures set forth in Q&A 3 of Part 1.

(b) *Medicare Retirees*: If you are an Eligible Retiree who is covered by Medicare and enrolled in Medicare Supplement or Medicare Advantage, CMS will provide confirmation of payment of your insurance premiums on your behalf, and at the beginning of each month, Albemarle will make a $275 monthly contribution to your Account for reimbursement.

2. Who can become a Participant in the Plan?

To become eligible to receive monthly contributions from Albemarle to your Account for the following Plan Year, you must enroll in a Mercer Plan no later than December 31 of the previous Plan Year. If you first become an Eligible Retiree after the designated enrollment period has ended, you will have 30 days from the date of retirement to enroll in a Mercer Plan to become eligible to receive a reimbursement.

Once you become or remain a Participant in this Plan, the Plan will maintain an Account in your name to keep a record of the amounts available to you for monthly reimbursement of the insurance premiums for coverage under the Mercer Plans.

Participants will cease to participate in the Plan, effective immediately, if either (a) he or she again becomes an active employee after having retired, or (b) elects not to continue participation in the Plan prior to December 31 for the subsequent Plan Year.

For more information on how to enroll in insurance coverage in a Mercer Plan through the Mercer Marketplace, contact Mercer Marketplace at 1-800-685-6350 or visit their website at www.retiree.mercermarketplace.com/albemarle.

3. How do Participants obtain a reimbursement under this Plan?

If you are a Medicare Eligible Retiree and have enrolled in Medicare Supplement or Medicare Advantage, CMS will submit proof of insurance premiums payments on your behalf, so you are not required to file a claim to obtain a reimbursement from your Account.

If you are a Non-Medicare Eligible Retiree, in order to obtain a reimbursement under the Plan, the following procedures need to be followed:

1. You must submit a claim for reimbursement of insurance premiums in writing to the Plan Administrator. The forms for reimbursement will be provided by a Mercer representative once your enrollment has been completed; and

2. Your request for payment must relate to insurance premiums for medical or prescription drug coverage purchased under a Mercer Plan during the time you were a Participant under this Plan.

If your claim is received by Plan Administrator on the 10th day of the month, Albemarle will reimburse you in the same month. If your claim is submitted after the 10th day of the month, reimbursements will be made in the following month.

4. What Benefits are offered under the Plan?

Your Account is merely a notional recordkeeping account; it tracks the credits and disbursements from your Account, but it does not bear interest or accrue earnings of any kind. Before the start of each Plan Year, Albemarle will determine the amount of the monthly contribution that may be made to each Eligible Retiree's Account for that Plan Year.

All reimbursements paid to you from the Plan come from Albemarle's general assets. To the extent you are a non-Medicare Eligible Retiree whose claim has been approved by the Plan Administrator or a Medicare Eligible Retiree whose Account has been funded for a monthly reimbursement, your Account will be reduced by any amount paid to you, or for your benefit, for insurance premiums that you pay to purchase coverage through the Mercer Marketplace. The amounts available for reimbursement as of any given date will be the total amount credited to your Account as of such date, reduced by any prior reimbursements made to you as of that date.

5. Are Benefits taxable to Participants?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the Plan generally are not taxable to you. The credit paid to an Account is generally excludable from your taxable income.

However, Albemarle cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. To the extent you might be eligible to receive a premium tax credit to help pay for coverage purchased on a public marketplace, you should consult your own tax advisor to determine if you qualify for such tax credit and whether your participation in this Plan would adversely affect you.

6. Will Participants have any administrative costs under the Plan?

Generally, no. Albemarle is currently bearing the entire cost of administering the Plan.

7. What happens if the Participant ceases to be an Eligible Retiree?

If you return to work as an active employee, your eligibility to participate in the Plan will terminate effective immediately. Any unused portions in your Account cannot be used to reimburse you for insurance premium costs that you incur while you are an active employee.

If you cease to be an Eligible Retiree for any other reason, including but not limited to death, your participation in the Plan will terminate at the end of the month in which the terminating event occurs. Your participation will also end when your Account balance has been exhausted or forfeited (to the extent you elect not to participate in the Plan for the subsequent Plan Year).

In either case, you will be reimbursed for any eligible insurance premium expenses prior to the date your participation terminates, up to your Account balance, provided that you comply with the reimbursement request procedures required under the Plan.

8. How long will the Plan remain in effect?

Although Albemarle expects to maintain the Plan indefinitely, it has the right to terminate the Plan at any time. Albemarle also reserves the right to amend the Plan at any time and in any manner that it deems reasonable, in its sole discretion. An amendment or termination of the Plan could result in the reduction or elimination of Account balances under this Plan.

In the event this Plan terminates, you will no longer be reimbursed for insurance premiums with any unused funds remaining in your Account. In other words, any unused funds in your Account will be forfeited at termination.

9. Are Participants permitted to suspend or permanently opt out of the Plan?

Yes, you may elect to suspend your Account for any future Plan Year by submitting a Suspension Election Form to the Plan Administrator before the beginning of that Plan Year. Your suspension election will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year.

By electing to suspend your Account for a Plan Year, you agree to permanently forgo reimbursements from your Account for insurance premiums.

10. Who is the Plan Administrator?

Albemarle is the Plan Administrator and the named fiduciary for the Plan.

11. What happens if the Participant's claim for Benefits is denied?

If your claim for Benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for Benefits are discussed below.

A. When will Participants receive a decision on a claim?

In the case of a claim for benefits, the following timetable for claims applies:

Notification of whether claim is accepted or denied	90 days
Extension due to special circumstances	90 days
Notification of benefit determination on review	60 days
Extension due to special circumstances	60 days

B. What information will a notice of denial of a claim contain?

If your claim is denied, the written notice that you receive from the Plan Administrator will include the following information:

- The specific reason for the denial;
- A reference to the specific Plan provision(s) on which the denial is based;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA § 502(a) following a denial of an adverse benefit determination on review; and
- If the Plan Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

C. Do Participants have the right to appeal a denied claim?

Yes, you have the right to an appeal of an adverse benefit determination. You will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

D. Do Participants have to appeal a denied claim before filing a lawsuit?

You will not be allowed to take legal action against the Plan, the Employer, the Plan Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you fully exhaust your appeal rights.

E. What are the requirements of an appeal?

Your appeal must be in writing, must be provided to the Plan Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Plan Administrator's act or omission;
- The date of the notice that the Plan Administrator informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Plan Administrator's act or omission.
- You should also include any documentation that you have not already provided to the Plan Administrator.

F. Is there a deadline for filing an appeal?

Yes. Your appeal must be delivered to the Plan Administrator no later than 180 days after receiving the denial notice or the Plan Administrator's act or omission. If you do not file your appeal within this 180-day period, you lose your right to appeal. Your appeal will be heard and decided by the Plan Administrator.

G. How will an appeal be reviewed?

Any time before the appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Plan Administrator. A document, record, or other information shall be considered relevant to a claim if it:

(a) was relied upon in making the claim determination;

(b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

Notice of a denial on review will contain the information listed in Part I, Paragraph 11(B) as well as: (i) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information pertinent to your claim for benefits; (ii) notice of your right to file suit under ERISA Section 502(a); and (iii) notice of your right to pursue other voluntary alternative dispute resolution options, such as mediation. To find what may be available under this option, contact your local U.S. Department of Labor office and State insurance agency.

H. When will the Plan Administrator notify Participants of the decision on appeal?

The Plan Administrator must notify you of the decision on your appeal within 60 days after receipt of your request for review unless the Plan Administrator notifies you of special circumstances that warrant a 60-day extension of time, but such extension shall be no longer than 60 days from the initial period.

I. May a Participant file a lawsuit against the Plan?

Yes, provided that you have fully exhausted the claims procedures herein. All interpretations, determinations and decisions of the Plan Administrator with respect to any claim shall be made in their sole discretion and shall be final and conclusive.

12. Is there information about this Plan in a language other than English?

This booklet contains a summary in English of your plan rights and benefits under the Albemarle Health Reimbursement Arrangement Plan for Retirees. If you have difficulty understanding any part of this booklet, contact Mercer Marketplace at 1-800-685-6350 or visit their website at www.retiree.mercermarketplace.com/albemarle.

PART II

ADMINISTRATIVE INFORMATION

1. Is there General Plan Information?

The Albemarle Health Reimbursement Arrangement Plan for Retirees is the name of the Plan. The Plan is a group-health plan intended to qualify as an employer-provided self-funded medical reimbursement plan under Code §§ 105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45. The Plan is paid for by Albemarle out of its general assets. There is no trust or other fund from which Benefits are paid.

Albemarle has assigned Plan Number 522 to your Plan. Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

2. Employer Information

Your Employer's name, address, and identification number are:

Albemarle Corporation
4360 Congress Street
Charlotte, NC 28209

TIN: 54-1692118

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Albemarle Corporation
4360 Congress Street
Charlotte, NC 28209

The Plan Administrator has full discretion to administer the Plan and all of its details and determine all questions arising in connection with the administration and application of the Plan. You may contact the Plan Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

Karen L. Narwold
Senior Vice President and General Counsel
Albemarle Corporation
4360 Congress Street
Charlotte, NC 28209

5. Type of Administration

The Plan Administrator pays applicable Benefits from Albemarle's general assets. The Plan Administrator, after receiving consent from Albemarle, may delegate administrative functions to other parties and may appoint such legal and actuarial counsel, accountants, and such other agents, including a claims administrator as it may deemed necessary to administer the Plan.

6. Claims Submission

Claims for expenses should be submitted to:

Albemarle Corporation
4360 Congress Street
Charlotte, NC 28209

PART III

ERISA RIGHTS

As a Participant in the Plan, you may be entitled to certain rights and protection under ERISA and the Code, but only to the extent ERISA is applicable to a particular portion of the Plan. ERISA provides that all Plan Participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;

- Obtain copies of all Plan documents and other plan information upon written request to the Administrator (the Administrator may charge a reasonable amount for the copies); and

- Receive a summary of the Plan's annual information report.

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

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may request the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court

may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

PART IV

HIPAA PRIVACY RIGHTS

Group health plans, including the Plan, are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Plan Administrator that outlines its health privacy policies, including with regard to electronic PHI.

PART V

MISCELLANEOUS

Effect of the Plan on Your Employment Rights

The Plan is not to be construed as giving you any rights against the Plan except those expressly described in this document. The Plan is not a contract of employment between you and the Employer.

Prohibition Against Assignment of Benefits

No Benefit payable at any time under the Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

Overpayments or Errors

If it is later determined that you received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the Plan.

If you do not refund the overpayment or erroneous payment, the Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.