BENEFITS
For a Healthy Life

ACCOUNTABILITY

2018 BENEFITS eGUIDE

AWARENESS

HOW TO USE THIS eGUIDE

This Benefits eGuide is designed for viewing on your computer. Use your mouse or touchpad to click on the buttons along the bottom of the page to move around the eGuide and perform other functions.

PERSONAL CHOICE

we are one
Sibanye Stillwater
Salaried Employees

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For a Healthy Life!

WELCOME! At Sibanye-Stillwater (or the Company), we are truly dedicated to the health and safety of our employees and their families — and it shows. Our benefits package is the best in the region and one of the best in the mining industry overall. This 2018 Benefits eGuide highlights the key features of the benefits programs of Sibanye-Stillwater and was designed to help you navigate and understand the benefits available to you so you can make informed decisions for you and your family and use your benefits wisely.

MEDICARE PART D — If you (or your eligible family members) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. See page 33 for more information.

IMPORTANT NOTICE — This is not a legal document. This 2018 Benefits Enrollment Guide is intended to be only a summary of the benefits available to you and does not include all plan rules, notices and details and is not to be considered a certificate of coverage or a summary plan description. While every effort was taken to accurately report your benefits, discrepancies and omissions are always possible. If for any reason there is a discrepancy between the official plan documents or official summary plan descriptions and this 2018 Benefits Enrollment Guide, the plan documents or summaries will always govern. Please refer to your summary plan descriptions, plan brochures and supporting literature for complete plan details and more detailed explanations as to coverages, limitations, and exclusions. Sibanye-Stillwater reserves the right to change, amend or terminate any benefit plan, with or without notice.

SIBANYE-STILLWATER FAMILY WEBSITE

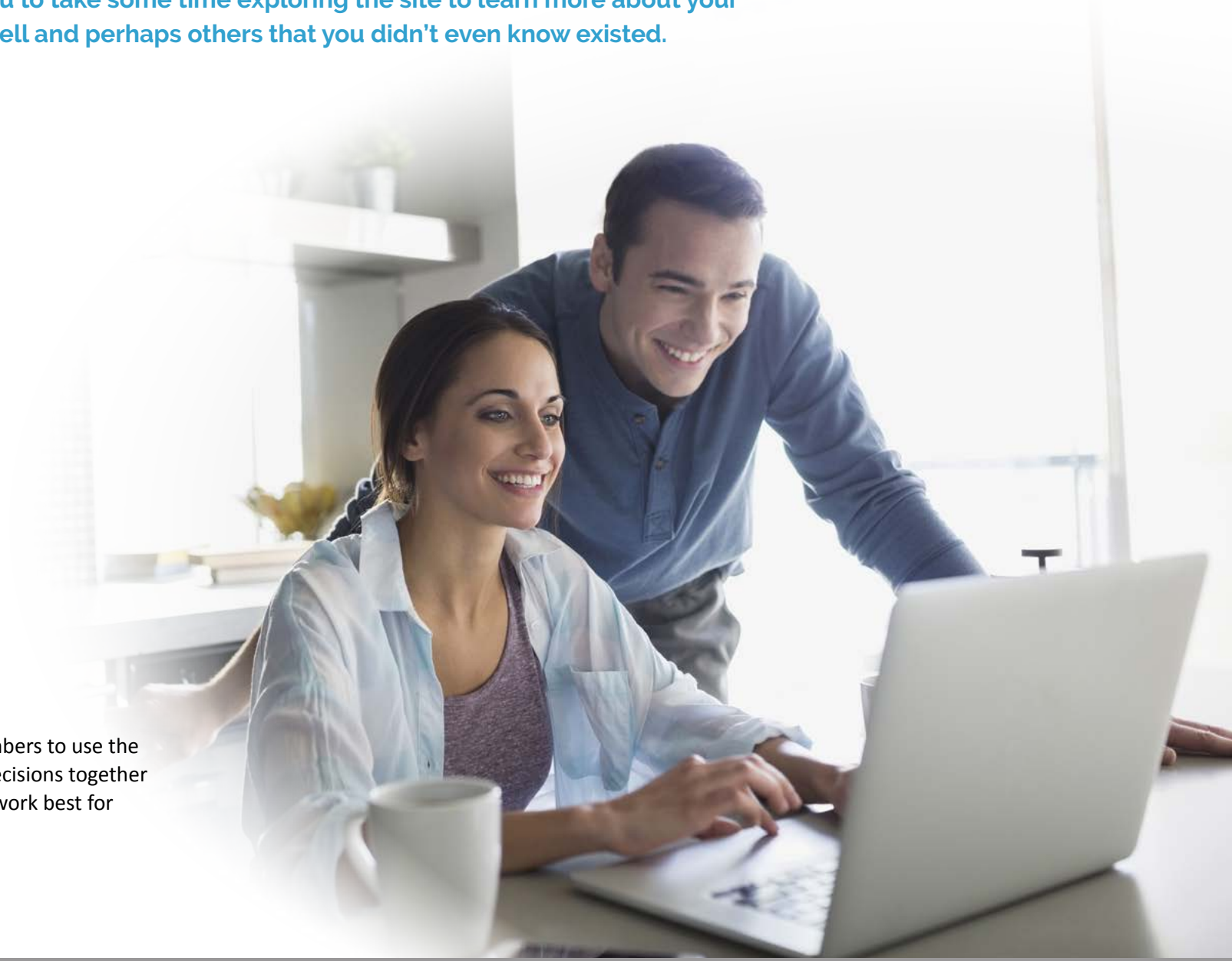
For a Healthy Life!

Sibanye-Stillwater's Family Website at www.stillwaterfamily.org is your one-stop destination to find must-have information for you and your family to make the most of our benefit plans and programs. We encourage you to take some time exploring the site to learn more about your benefits — ones you know well and perhaps others that you didn't even know existed.

Here's what you'll find:

- Benefits Info
- Change Forms
- Provider Contact Information
- Wellness Rocks
- Safety
- Financial Wellness
- Retirement Plan
- Payroll
- Perks
- General Employee Info
- Scholarships
- Family Outings
- Blog
- Contact Info
- Employee Appreciation Days

We also encourage your family members to use the site as well, so that you can make decisions together about the plans and programs that work best for everyone in your life.



ELIGIBILITY & ENROLLMENT

For a Healthy Life!

Who is Eligible?

You are considered benefits-eligible if you are an active full-time employee regularly scheduled to work 30 or more hours per week. You may also enroll your eligible family members for coverage under the same plans you choose for yourself.

Your eligible family members include:

- Your spouse
- Your natural child, stepchild, or adopted child, or other child for whom a court holds you responsible:
  - Children are eligible from birth up to age 26, whether or not they're living apart from you, dependent on you for support, a student, married, or eligible for other coverage from their own job (or spouse's job).
  - Children age 26 and older who are physically or mentally incapable of self-support may continue on your Sibanye-Stillwater Health coverage if the disability continues. The child must already be covered under the plan. You may be asked to provide certification of the child's disability annually.

When Am I Eligible?

Eligibility for benefits differs between coverages, as follows:

- **Medical, Dental, Vision, Flexible Spending Accounts (FSAs), Employee Assistance Program (EAP), and 24/7 Nurseline:** First day of the month following your date of full-time employment or qualifying Change in Status (see page 5 for details).
- **Basic Life Insurance, Basic AD&D Insurance, and Voluntary AD&D Insurance:** Date of full-time employment or qualifying Change in Status.
- **Voluntary Life Insurance:** Date of full-time employment or qualifying Change in Status. Coverage elections in excess of the Guaranteed Issue amount become effective upon approval from the insurance carrier (see page 29 for details).
- **Short Term Disability and Long Term Disability:** The day you complete one year of continuous full-time active employment.
- **Retirement - 401(k):** 30 days after your date of hire.

How Do I Enroll?

You must complete the necessary enrollment forms and return them to Human Resources within 31 days following your date of hire or a qualifying Change in Status event. If you fail to enroll on time you will be enrolled in only the Sibanye-Stillwater-paid benefits and will have to wait until the next annual Open Enrollment period to enroll, unless you experience a Qualifying Change in Status event (see page 5 for details).

You CANNOT have duplicate coverage under the Sibanye-Stillwater Health plans.

- **If you and your spouse are both Sibanye-Stillwater employees, and you enroll in the Health Plan, you cannot also be covered as a dependent of your spouse.**
- **Children who have both parents working at Sibanye-Stillwater cannot have duplicate coverage under both parents.**
- **Married children who have both a parent and a spouse working at Sibanye-Stillwater cannot have duplicate coverage under both the parent and spouse.**

MAKING ELECTION CHANGES

For a Healthy Life!

CHOOSE YOUR BENEFITS CAREFULLY!

Internal Revenue Service (IRS) regulations allow you to change your Medical, Dental, Vision, and Flexible Spending Account (FSA) elections only during an annual Open Enrollment period. However, if you experience a qualifying Change in Status event during the year, you may change your benefit plan elections before the next Open Enrollment period, as long as you notify HR of the change within 31 days after the qualifying event. You can only make changes to your benefits as they relate to your qualifying Change in Status.

Open Enrollment

Annual Open Enrollment, usually held in October/November each year, is typically the only time of the year when you may enroll or change current benefit elections for coverage effective January 1. You will be notified annually when the next Open Enrollment period will take place and we will also communicate to you any changes to the benefit plans.

Qualifying Change in Status

Following are examples of a qualifying Change in Status event:

- You get married, divorced or legally separated
- You have a baby or adopt
- Your child reaches the maximum age limit
- Your enrolled family member passes away
- You move from full-time to part-time, or vice versa
- You lose coverage under your spouse's employer's plan or a parent's plan
- You are served with a judgment, decree, or court order (including a qualified medical child support order) regarding benefits coverage for a child

How to Report a Qualifying Change in Status

If you experience a qualifying Change in Status event and wish to make election changes, you MUST submit an Enrollment/Change Form to Human Resources **within 31 days** of the qualifying event date (including newborns). Be prepared to provide documentation to support the Change in Status (e.g., marriage license, birth certificate, divorce decree). If changes are not submitted within the 31 days, you will not be allowed to make changes until the next annual Open Enrollment period, unless you experience another qualifying Change in Status event.

Changes become effective on the first day of the month beginning after the date the completed request for enrollment is received, except when the change is due to the birth or adoption of a child. In these cases, coverage becomes effective on the date of the event.

BENEFITS SUMMARY / CONTACT INFO

For a Healthy Life!

Benefits	Provider / Administrator	Phone Number	Website / Email
Medical	Blue Cross Blue Shield of Montana (BCBSMT)	1-855-258-3489	www.bcbsmt.com/member
Prescription Medications	Express Scripts administered by RxBenefits	1-800-334-8134	www.express-scripts.com
24/7 Nurseline	Blue Cross Blue Shield of Montana (BCBSMT)	1-877-213-2565	1-877-213-2565
Well onTarget	Blue Cross Blue Shield of Montana (BCBSMT)	1-855-258-3489	www.bcbsmt.com/member Click on the Well onTarget link
Employee Assistance Program	Mines & Associates	1-800-873-7138 (available 24/7)	www.minesandassociates.com • User Name: stillwater • Password: employee
Dental	Blue Cross Blue Shield of Montana (BCBSMT)	1-866-739-4090	www.bcbsmt.com/member
Vision	Vision Services Plan (VSP)	1-800-877-7195	www.vsp.com
Flexible Spending Accounts	ConnectYourCare	1-866-808-1444 1-443-681-4602 (fax)	www.connectyourcare.com
Leave of Absence	Principal Financial Group / FMLASource	1-866-825-1632	www.principal.absencemgmt.com LeaveCenter@principal.absencemgmt.com
Life Insurance & Disability	Principal	1-866-825-1632	www.principal.com
AD&D Claims	Cigna	1-800-362-4462	www.mycigna.com
Supplemental Benefits (Accident, Cancer, and Hospital Indemnity)	Aflac	Enrollment & Plan information: Dee Dee Cummings: 1-406-245-9011	www.aflac.com
Retirement - 401(k)	Prudential	1-877-778-2100	http://stillwater.retirepru.com/
Financial Wellness	Financial Finesse	1-888-450-2881 (toll-free) Monday - Friday, 7 A.M. – 6 P.M. MDT	N/A
Secure Travel	Cigna	From the U.S. & Canada: 1-888-226-4567 Other locations: 1-202-331-7635 (call collect) Policy# OK968037 / Group# 57	N/A

www.stillwaterfamily.org

Human Resources: 1-406-322-8930

BENEFITS COSTS FOR 2018

For a Healthy Life!

Sibanye-Stillwater pays the majority of your Medical, Dental and Vision costs. You pay your share of the costs each pay period through convenient pre-tax payroll deductions. Pre-tax means that the income you use to pay for these benefits is not taxed, putting dollars back into your pocket.

2018 Benefit Costs	Semi-Monthly You Pay	Monthly You Pay	Monthly Sibanye-Stillwater Pays	Total Premium Cost
MEDICAL & Rx				
Employee Only	$83.53	$167.05	$668.20	$835.25
Employee & Spouse	$156.98	$313.95	$1,255.82	$1,569.77
Employee & Child(ren)	$128.20	$256.40	$1,025.61	$1,282.01
Employee & Family	$202.23	$404.45	$1,617.82	$2,022.27
DENTAL				
Employee Only	$4.95	$9.90	$39.65	$49.55
Employee & Spouse	$9.59	$19.18	$76.67	$95.85
Employee & Child(ren)	$7.71	$15.42	$61.68	$77.10
Employee & Family	$12.33	$24.66	$98.69	$123.35
VISION				
Employee Only	$0.00	$0.00	$10.31	$10.31
Employee & Spouse	$3.69	$7.37	$10.31	$17.68
Employee & Child(ren)	$4.21	$8.41	$10.31	$18.72
Employee & Family	$8.92	$17.84	$10.31	$28.15

HEALTH CARE CONSUMER TIPS

For a Healthy Life!

Sibanye-Stillwater's health care plans are self-funded. This means that Sibanye-Stillwater pays the actual cost of your health care claims, not an insurance company. Your paycheck contributions help to offset those costs. Our insurance carriers are simply contracted as third party providers to administer the plans.

The expense of health care claims drives the cost of health care. When you take an active role in your health care and stay healthy, this helps manage benefit costs. Only when we are all responsible health consumers and active partners in utilizing our benefits properly can we be successful in maintaining a quality benefits program at an affordable cost.

You can make a difference!

Stay healthy.

The biggest way to save on health care costs is to be healthy. Work with your doctor to learn ways to stay healthy through exercising, eating a balanced diet, modifying your lifestyle, quitting smoking and other preventive measures. When you are healthier, you end up spending less for doctors, hospitals, and prescription medications, and you will feel better and have more money to spend on other things you enjoy.

Get your annual preventive care exams.

They're covered at 100% when you use in-network providers and can help identify any potential health problems early on.

Use in-network providers.

Your provider network is an important part of your coverage. When you go to in-network providers you receive the highest level of benefits at pre-negotiated reduced rates and pay the lowest out-of-pocket expenses. When you get a referral to another doctor or hospital, check to make sure that the provider is in-network.

Take advantage of disease and nurse management services.

These services are available at **NO COST** and assist health plan members who have complicated or chronic health issues, helping you to improve your health outcome, reduce your health care costs, and address your individual medical needs. These services also help members understand their conditions and how to navigate the complex healthcare and treatment services available.

Know your health coverage.

Use all of the resources available to you to learn everything you can about your health plans — from costs to prescriptions, and everything in between.

Ask for generic medications.

Using generic medications can save you money. The U.S. Food and Drug Administration (FDA) requires that generic medications have the same active ingredients and take the same form (such as pill or liquid) as their brand-name equivalents. Speak to your physician about generic options.

Consider an urgent care center.

If you have a non-emergency situation that requires immediate care, consider an urgent care center rather than a hospital emergency room, when possible. The costs for services received in an urgent care facility will be lower than a hospital emergency room, and the waiting time for treatment is typically shorter.

Urgent Care: basic illness/injury, stitches/sutures, fever.

Emergency Room: any life threatening condition, chest pain, shortness of breath, serious bodily injury, severe abdominal pain, loss of consciousness.

MEDICAL PLAN

For a Healthy Life!

BlueCross BlueShield of Montana

Our medical plan is administered through Blue Cross Blue Shield of Montana (BCBSMT). This plan gives you the freedom to use the provider of your choice, with greater cost savings in-network.

IN-NETWORK — When you use providers who participate in the BCBSMT network, you receive the highest level of benefits and save on out-of-pocket expenses. These providers have agreed to discount their fees for their services and will file claims for you electronically, saving you time and hassle. In-network providers include those who participate in the following networks:

- **Montana Preferred Provider Organization (PPO):** This network is composed of hospitals and surgery centers across Montana. Currently, all hospitals in Montana participate in this network.
- **Blue Cross Blue Shield of Montana Network Participating Providers:** This is the most extensive provider network available in Montana, composed of professional providers (e.g., physicians, specialists, physical therapists, nurse practitioners). In Montana, approximately 95% of all physicians and 100% of all hospitals participate in this network.
- **World-Wide Network of Providers**: With BlueCard, you have access to participating providers across the country and around the world. No matter where you are, you'll receive the same great benefits you get when you're at home.

OUT-OF-NETWORK — The plan also provides benefits if you see a non-participating provider. When using an out-of-network provider, your out-of-pocket expenses will be higher, you will have to pay the provider in full at the time you receive care, and you will have to file a claim for reimbursement. Please also keep in mind that BCBSMT pays out-of-network claims based on their allowable fee. If a non-participating provider charges more than the allowable fee, you will be responsible for the difference. Here's an example: Suppose you have a chest X-ray (single view) performed by an out-of-network provider. The doctor charged $60.00 for this procedure and BCBSMT's maximum allowed amount for this service is $38.22. Here's what your total out-of-pocket costs would look like, **after your deductible has been met**:

Example:	In-Network (plan pays 80%)	Out-of-Network (plan pays 60%)
Provider's Charge	$38.22	$60.00
Maximum Allowed Amount	$38.22	$38.22
Plan Pays	$38.22 x 80% = $30.58	$38.22 x 60% = $22.93
You Pay	$38.22 x 20% = $7.64	$38.22 x 40% = $15.29
Additional Balance Billed by Your Provider	$0.00	$60.00- $38.22 = $21.78*
Your Total Costs	$7.64	$37.07

*Note: *Out-of-network charges above the plan's maximum allowed amount do not count toward your deductible or out-of-pocket maximum.*

How to Locate an In-Network Healthcare Provider

1. Visit www.bcbsmt.com/member
2. Click **Find a Doctor with Provider Finder**
3. Select **Montana** and click **Start Search**
4. Select Plan Network **Blue Preferred PPO**
5. Enter your Search Criteria and click **Search**

Or call 1-855-258-3489

World-Wide Network of Providers:

To find an in-network provider outside the state of Montana or around the world, visit www.provider.bcbs.com or call 1-800-810-BLUE (2583). **Note:** You will need the prefix (the first 3 letters of your Identification Number on your ID card) in order to perform this search.

MEDICAL PLAN (continued)

For a Healthy Life!

Medical Plan Highlights

The chart below provides a high-level overview of your medical plan benefits.

BlueCross BlueShield of Montana

Key Medical Benefits	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE – Per Calendar Year		
Individual	$200	
Family	$400	
The deductible applies to ***all*** covered expenses (except routine preventive care) and must be satisfied each calendar year before any benefits will be paid.		
OUT-OF-POCKET MAXIMUM – Per Calendar Year		
Individual	$1,200	$1,450
Family	$2,400	$2,900
Maximums include the deductible and count towards each other. Once you reach the out-of-pocket maximum, the Plan will pay 100% of covered expenses up to the BCBSMT allowable amount for the remainder of the calendar year. If you receive services from an out-of-network provider, the provider may balance bill you for the difference in the BCBSMT allowance and their charge.		
COVERED SERVICES		
Office Visits	Covered 80% (after deductible)	Covered 60% (after deductible)
Hospital Room & Board	Covered 80% (after deductible)	Covered 60% (after deductible)
Preventive Care Services (see page 17 for covered services)	Covered 100% DEDUCTIBLE WAIVED	Covered 80% DEDUCTIBLE WAIVED
Accidents	Covered 100% of the first $500- within first 90 days of accident (deductible waived); thereafter covered 80% (after deductible)	Covered 80% of the first $500- within first 90 days of accident (deductible waived); thereafter covered 60% (after deductible)
Ambulance Services	Covered 80% (after deductible)	Covered 80% (after deductible)
Applied Behavioral Analysis (ABA)	Covered 80% (after deductible)	Covered 60% (after deductible)
	Children up to age 18 only- Provides screening, assessment, and treatment of autism spectrum disorders	
Chiropractic Care	Covered 80% (after deductible)	Covered 60% (after deductible)
	35 visits per calendar year	

MEDICAL PLAN (continued)

For a Healthy Life!

Medical Plan Highlights (continued)

The chart below provides a high-level overview of your medical plan benefits.

BlueCross BlueShield of Montana

Key Medical Benefits	IN-NETWORK	OUT-OF-NETWORK
COVERED SERVICES		
Diagnostic X-ray & Lab	Covered 80% (after deductible)	Covered 60% (after deductible)
Durable Medical Equipment, Orthotics, and Prosthetics	Covered 80% (after deductible)	Covered 60% (after deductible)
	Foot orthotics limited to 1 per foot, per year	
Emergency Room	Covered 80% (after deductible)	Covered 80% (after deductible)
Hearing Aids	Covered 80% (after deductible)	Covered 80% (after deductible)
Home Health Care	Covered 80% (after deductible)	Covered 60% (after deductible)
	180 visits per Calendar Year maximum	
Mental Health	Covered 80% (after deductible)	Covered 60% (after deductible)
Substance Abuse	Covered 80% (after deductible)	Covered 60% (after deductible)
Organ Transplants (Benefit will be applicable only when utilizing a Blue Distinction Center (BDC) transplant facility)	Covered 80% Donor Procurement / Travel / Lodging limited to $500,000 per Lifetime; all other services are unlimited.	Not Covered
Outpatient Therapies (Physical, Occupational, and Speech Therapy)	Covered 80% (after deductible)	Covered 60% (after deductible)
	25 visits per Calendar Year, per therapy	
Rehabilitation Therapy	Covered 80% (after deductible)	Covered 60% (after deductible)
Skilled Nursing Facility	Covered 80% (after deductible)	Covered 60% (after deductible)
	100 days per Calendar Year maximum	

PRESCRIPTION MEDICATIONS (Rx)

For a Healthy Life!

Pharmacy benefit services are provided by Express Scripts administered by RxBenefits.

Please contact RxBenefits Member Services at 1-800-334-8134 with questions regarding your prescriptions.

Our prescription plan includes three levels of copayments. Your prescription drug copay will depend on the type of prescription being purchased:

1. **Generic (first-tier) has the lowest copayment.** Generic medications may be an effective substitute for their brand name counterparts and cost significantly less. Ask your physician if a suitable, alternative generic prescription drug is available.
2. **Preferred Brand-Name (second-tier) have a higher copayment.** Medications that are preferred by the health plan.
3. **Non-Preferred Brand-Name (third-tier) have the highest copayment.** Medications that are not on the list of preferred medications.

Starting in 2018, you will be able to fill your prescriptions at Walgreens.

Rx PLAN HIGHLIGHTS *The information for your prescription medication coverage is included on your BCBSMT member ID card. RxBenefits does not issue separate ID cards for our Plan.*		
Rx Benefits	30-DAY SUPPLY Pharmacy Option	90-DAY SUPPLY Pharmacy Option** or Mail Order Option for Maintenance Drugs
Generic	$5	$10
Preferred Brand-Name*	$20	$40
Non-Preferred Brand-Name*	$30	$60
Specialty Medications	Specialty medications are limited to a 30-day supply and must be ordered from Accredo Specialty Pharmacy at 1-800-803-2523. Specialty medications may require prior authorization, step therapy or quantity limits.	
Out-of-Pocket Maximum	$5,400/Individual and $10,800/Family The annual out-of-pocket maximum provides protection against catastrophic drug costs. Once the annual out-of-pocket maximum is met, prescription drugs are covered 100% for the remainder of the calendar year.	

* As defined by the pharmacy benefit manager. See Summary Plan Description for clarification.

** At select participating pharmacies. See Summary Plan Description for further details.

Save Money On Your Maintenance Prescriptions!

If you are taking a medication daily or for an extended period of time, sign up for the Mail Order program, or ask your local pharmacist if you can fill your maintenance prescriptions for 3 months for only 2 copayments! To find out if your prescription is considered a maintenance drug, please call RxBenefits Member Services at 1-800-334-8134.

RxBenefits

EXPRESS SCRIPTS®

Register Online at:

www.express-scripts.com

- Make arrangements to receive home delivery of your prescriptions
- Order refills
- Track the status of your order
- Receive status notifications and reminders
- Check your benefit coverage
- Locate participating retail pharmacies near you

GET THE APP! The Express Scripts App is available for FREE from the iTunes App or Google Play stores.

DENTAL PLAN

For a Healthy Life!

BlueCross BlueShield of Montana

Staying healthy includes regular visits to a dentist for cleanings, X-rays and check-ups.

Our PPO dental plan is administered through Blue Cross Blue Shield of Montana (BCBSMT). This plan gives you the freedom to use the provider of your choice. Providers who participate in the BCBSMT network will file claims for you electronically, saving you time and hassle. When using an out-of-network provider, you will have to pay the provider in full at the time you receive care and file a claim for reimbursement.

Key Dental Benefits	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE – Per Calendar Year (for major services and implants only)		
Individual / Family	$50 / $100	
COVERED SERVICES		
Preventive & Diagnostic Services • Oral Exams • X-rays • Cleanings • Sealants (children under age 16) • Space Maintainer (children under age 19) • Fluoride (children under age 19)	Plan pays 100%	Plan pays 100%
Basic Services • Fillings • Extractions • Root Canals • Periodontics (gum treatment) • Crowns	Plan pays 80%	Plan pays 80%
Major Services • Dentures • Bridges • Inlays & Onlays	Plan pays 50% (after deductible)	Plan pays 50% (after deductible)
Orthodontia (Adults & children)	Plan pays 50%	Plan pays 50%
Non-Surgical Treatment of TMJ	Plan pays 50%	Plan pays 50%
Implants	Plan pays 50% (after deductible)	Plan pays 50% (after deductible)
MAXIMUM BENEFIT AMOUNT		
Preventive, Basic, and Major Services combined	$2,000 per Member per Calendar Year	
Orthodontia	$2,000 per Member per Lifetime	
Non-Surgical Treatment of TMJ	$500 per Member per Lifetime	

How to Locate an In-Network Dental Provider

1. Go to: www.bcbsmt.com/member
2. Click **Find a Doctor** with Provider Finder
3. Select **Montana** and scroll down and select **Find a Dentist** under 'more searches'
4. Select Plan Network **Blue Care Dental**
5. Enter your **Search Criteria** and click **Search**

Or call **1-855-258-3489**

VISION PLAN

For a Healthy Life!

Regular vision care is essential to your overall health.

Our vision plan is administered through VSP. When you use providers in the VSP *Signature* network, you receive the highest level of benefits and save on out-of-pocket expenses. After you pay the annual copayment, most services are covered in full. VSP's provider network offers a wide choice of private practice optometrists, ophthalmologist, and opticians.

VSP Vision care for life

Key Vision Benefits	In-Network	Out-of-Network Reimbursement[1]
Copay	$25 copay for exam and eyeglasses (once per year)	
Eye Exam (one exam every calendar year)	Covered in full*	Up to $46*
Lenses (one pair every calendar year)	Covered in full* • Includes: single vision, lined bifocal, lined trifocal, and lenticular. • 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last exam.	• Single: up to $55* • Bifocal: up to $75* • Trifocal: up to $95* • Lenticular: up to $125* *All other lenses are not covered*
Lens Enhancements (once every calendar year)	Covered in full* • Includes: progressive lenses, anti-reflective coating, tints/photochromic adaptive lenses, polycarbonate lenses, scratch-resistant coating, polarized lenses • Average savings of 35-40% on other enhancements	• Tints/Photochromic lenses-Transitions: up to $5 • Progressive lenses: up to $95 *All other lens options are not covered*
Frames (one set every other calendar year)	• $130 allowance for a wide selection of frames* • $150 allowance for featured frame brands* • 20% off amount over your allowance	Up to $45*
Contact Lenses (once every calendar year; instead of eyeglasses[2])	• $130 allowance for contacts (no copay) • Up to $60 copay for contact lens exam	Up to $105 for contacts and the contact lens exam (no copay)
Laser Vision Correction	Average 15% off regular price or 5% off promo price	N/A
Hearing Aids through TruHearing	TruHearing offers VSP members free membership and deep discounts on some of the most popular digital hearing aids on the market. To learn more and sign up, visit: www.vsp.truhearing.com.	

** After $25 copay (once per year).*

1. When you use an out-of-network provider, your out-of-pocket cost will be higher, you will have to pay the provider in full at the time you receive care, and you will have to file a claim with VSP for reimbursement.

2. If you choose contact lenses instead of eyeglasses, you will be eligible for a frame one calendar year from the date the contact lenses were obtained.

How to Locate a VSP Vision Provider

1. Visit www.vsp.com
2. Click Find a Doctor
3. Select the VSP **Signature** Doctor Network

You may also call 1-800-877-7195

NOTE: VSP does not issue ID cards. The VSP provider will check your eligibility and your enrolled family member's eligibility using the **employee's** name, date of birth and the last four digits of the **employee's** Social Security number (SSN).

BENEFITS YOU MAY BE OVERLOOKING

For a Healthy Life!

DON'T MISS OUT!

Here are 4 VALUABLE benefits you may be overlooking or not taking full advantage of.

❶ Financial Wellness

You and your family are provided with financial wellness benefits at **NO COST** to you. Sibanye-Stillwater realizes that it's important to have a reliable and trustworthy source at your disposal to help you make the best decisions for your financial future. That's why we are pleased to offer a Financial Wellness program, provided in partnership with the leading unbiased financial education firm in the country, Financial Finesse. Program includes a confidential Financial Helpline and Financial Planning Workshops.

See page 26 for details.

❷ Medical Programs

Medical plan members have access to the following programs through the BCBSMT Medical plan:

- **Care Coordination** — If you have a complex, difficult, chronic or lengthy illnesses, Clinical Care Coordinators are available to oversee your treatment and offer support, education, and assistance designed to improve your health outcome.
- **Special Beginnings** — This program provides education, support and early identification of risks to help expectant mothers achieve a full-term pregnancy.
- **Utilization Management** — If you are hospitalized for an emergency or are planning a hospitalization, BCBSMT's utilization management team is available to help ensure that health care services, procedures, and facilities are appropriate, timely, and efficient.

See page 18 for details.

❸ 24/7 Nurseline

The 24/7 Nurseline is your **FREE** link to health information. Do you have a sick child at home, but don't know if she needs medical attention? Are you feeling under the weather, but want to know if your symptoms can be treated at home? Simply call **1-877-213-2565** to get answers to many of your health care questions. Registered nurses are on hand to handle your questions and concerns 24 hours a day, 7 days a week. All calls are completely confidential!

See page 19 for details.

❹ Employee Assistance Program (EAP)

Through the EAP, you and each member of your household are eligible for up to **5 face-to-face counseling sessions per year, per issue - FREE OF CHARGE!** For the many personal issues and concerns that arise in life, your Employee Assistance Program is available any time, 24 hours a day, seven days a week. It is a free and confidential service that will provide counseling, telephonic consultation, and support services for you and your family members. In addition to counseling services for issues like stress, relationships, depression, grief and loss, substance abuse, etc., they also provide legal services, financial services and child care and elder care services.

See page 21 for details.

FAMILY & MEDICAL LEAVE ACT (FMLA)

For a Healthy Life!

Principal

FMLASource®

Employees are eligible to take time off work under the FMLA after completing twelve (12) months of employment and working 1,250 hours (actual hours worked) during the 12 months immediately preceding the commencement of the leave. FMLA entitles eligible employees to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

Reasons for Taking Leave

Eligible employees are entitled to up to 12 weeks of unpaid, job-protected leave:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son, daughter, or parent who has a serious health condition;
- To address certain qualifying exigencies arising from an employee's spouse, son, daughter, or parent on active duty or call to active duty in the National Guard or Reserves in support of a contingency operation;
- For incapacity due to pregnancy, prenatal medical care, or post-partum recovery;
- For a serious health condition that makes the employee unable to perform his or her job.

FMLA requires covered employers to provide a special leave entitlement of up to 26 weeks of unpaid, job-protected leave during a single, 12-month period to care for a child, parent, spouse or next of kin who is a covered service member. FMLA leave runs concurrently with Workers' Compensation leave and Short Term Disability leave. A covered servicemember is a current member of the Armed Forces (including Guard and Reserves), or a veteran who has been honorably discharged within the past five years, who has a serious injury or illness incurred or aggravated in the line of active duty that may render the servicemember medically unfit to perform his/her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Employee Responsibilities

Employee must provide 30-days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedure.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health-care provider, or the circumstances supporting the need for military family leave. Employees must also inform their employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees may also be required to provide a certification and periodic recertification supporting the need for leave.

Additional Leave Options

Outside of FMLA, Employees may be able to take unpaid leave while continuing group health insurance coverage. Other reasons to take a leave may include: (USERRA) - Military Leave, Jury Duty, Bereavement, or Non-FMLA Medical Leave. Please contact Principal Financial Group / FMLASource to learn more about additional leave options.

Managing your leave of absence is easier than ever!

Sibanye-Stillwater has contracted with Principal Financial Group / FMLASource to administer the leave process. To learn more about federal FMLA regulations, other leave options, or to begin the process of filing a claim, please contact Principal Financial Group / FMLASource in one of the following ways:

- 1-866-825-1632
- Email: LeaveCenter@principal.absencemgmt.com
- Online: www.principal.absencemgmt.com

When you file a claim, your information will be verified by a Leave Specialist who will initiate the leave process and answer any questions you may have.

PREVENTIVE CARE

For a Healthy Life!

BlueCross BlueShield of Montana

Our medical plan covers routine preventive care exams and screenings at 100% — with NO DEDUCTIBLE OR COPAY — when you go to an IN-NETWORK doctor.

Preventive care benefits include the following routine services: Office visits, physical examinations, well-child visits, X-rays and laboratory tests, hearing screening, vision screening* and all other screenings and preventive services which are recommended and graded A or B by the United States Preventive Services Task Force.

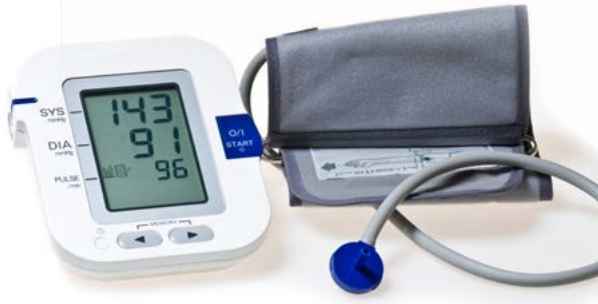
Preventive Care Benefits	In-Network	Out-of-Network
Routine Well Care (ages birth through adult)	COVERED 100%	Covered 80%
Breast Cancer Screening, Testing and Counseling	COVERED 100%	Covered 80%
Cervical Cancer Screenings	COVERED 100%	Covered 80%
Routine Colonoscopy / Flexible Sigmoidoscopy	COVERED 100%	Covered 80%
Diabetes Screening	COVERED 100%	Covered 80%
Dietary Education (including but not limited to diabetic education)	COVERED 100%	Covered 80%
Hypertension (High Blood Pressure) Screening and Counseling	COVERED 100%	Covered 80%
Hyperlipidemia (High Cholesterol) Screening and Counseling	COVERED 100%	Covered 80%
Immunizations and Vaccines (as adopted by the Director of Centers for Disease Control and Prevention)	COVERED 100%	Covered 80%
Prostate Specific Antigen (PSA) Test	COVERED 100%	Covered 80%
Tobacco Cessation Benefit (including screening, counseling and treatment)	COVERED 100%	Covered 80%
Obesity Screening, Counseling and Treatment (excluding surgery)	COVERED 100%	Covered 80%

*A vision screening is not a comprehensive vision exam. It is a relatively short examination that can indicate the presence of a vision problem or a potential vision problem. A vision screening cannot diagnose exactly what is wrong with your eyes; instead, it can indicate that you should make an appointment with an ophthalmologist or optometrist for a more comprehensive eye examination.

Preventive Care vs. Diagnostic Care

Preventive care helps protect you from getting sick. For example, if your doctor wants you to get a colonoscopy (a test that checks your colon) because of your age or because your family has a history of colon problems, that's called preventive care, and is covered 100% when you see an in-network provider.

Diagnostic care is used to find the cause of existing illnesses. If your doctor wants you to get a colonoscopy because you're having symptoms of a problem, like pain, that's called diagnostic care and charges will be incurred.



MEDICAL PROGRAMS

For a Healthy Life!

Medical plan members have access to the several programs through BCBSMT. By participating in these programs you can take an active role in managing your health care.

BlueCross BlueShield of Montana

To find out more about these programs, call BCBSMT at 1-855-258-3489.

Care Coordination

When you're in need of medical treatment, the health care system can seem like a complex maze of specialty providers, confusing lingo, and complicated treatment plans. BCBSMT Care Coordinators are available to help, acting as your personal guides to a healthier, more satisfying destination.

Registered nurses and licensed clinical social workers work as a single point of contact between patients, primary care providers, and multidisciplinary teams of providers. They facilitate proper communication, the formulation of appropriate treatment plans, patient education, compliance with treatment plans, and ultimately, healthy outcomes. **Participation in this program is voluntary and confidential**.

A Care Coordinator begins the process by making contact with patients to identify their needs. Based on your unique conditions and health status, a Care Coordinators will work with your providers to determine an appropriate, timely, and effective treatment plan.

Individuals who participate in the program have reported improved satisfaction, reduced costs, and positive health outcomes. Care Coordination helps you get the most out of your medical benefits, reduces your risk of "falling through the cracks" in the health care system, and it better positions you to recognize and react to your own health demands. In addition, Care Coordinators provide resources to help you deal with the effects of chronic or diagnosed conditions.

Clinical Care Coordinators:

- Offer support, education, and assistance designed to improve your health outcome
- Assist you in following your recommended treatment plan
- Encourage wellness and preventive services
- Identify ways to maximize your benefits
- Help you locate additional resources and participating providers
- Assist in preventing unnecessary readmissions

Utilization Management

If you are hospitalized for an emergency or are planning a hospitalization, BCBSMT's utilization management team helps ensure that health care services, procedures, and facilities are appropriate, timely, and efficient. Their staff is specially trained to identify the most medically appropriate treatment plans, and to act as your advocate during your hospital stay. To ensure you receive the right care, call and have your hospital stay certified.

Special Beginnings

Special Beginnings gives expectant mothers covered under the Sibanye-Stillwater Health Plan the tools they need to feel prepared and confident throughout pregnancy. Obstetric/Gynecological registered nurses provide support, education, and early risk identification, helping mothers achieve full-term, reduced-stress pregnancies. The result is healthier babies and happier moms. How it works: Expectant mothers are paired with a personal Maternity Case Manager who is an Obstetric/Gynecological registered nurse. In partnership with your health care provider, your Maternity Case Manager will:

- Answer questions and provide support
- Provide educational materials
- Explain treatment plans; coordinate special services, if necessary
- Provide postpartum follow up

FREE GIFT! Expectant mothers covered under the Sibanye-Stillwater Health Plan receive a free gift from Sibanye-Stillwater when they enroll in the Special Beginnings program during their first trimester *and* complete the program.

24/7 NURSELINE

For a Healthy Life!

BlueCross BlueShield of Montana

Answers to your health questions are just a phone call away!

Do you have a sick child at home, but don't know if she needs medical attention? Are you feeling under the weather, but want to know if your symptoms can be treated at home? Sometimes you just need a quick answer to a medical question that's worrying you. Our 24/7 Nurseline program lets you get simple answers to simple questions fast!

Nurses are available 24 hours a day, 7 days a week!

1-877-213-2565

Program Features:

- Program is available to you and your covered family members at **NO COST**
- Registered nurses are on hand to handle your questions and concerns 24 hours a day, 7 days a week
- All calls are completely **CONFIDENTIAL!**
- There is no limit on the number of times you may call 24/7 Nurseline
- They may suggest a home remedy, a visit to your primary care physician, or recommend a community agency or support group
- If it's urgent, they will recommend a visit to the emergency department

When should you call?

The toll-free Nurseline can help you or a covered family member get answers to health problem questions, such as:

- Asthma or chronic health issues
- Dizziness or severe headaches
- High fever
- Cuts or burns
- Sore throat

Plus, when you call, you can access an audio library of more than 1,000 health topics—from allergies to women's health.

WELL ONTARGET WELLNESS PROGRAM

For a Healthy Life!

Experience a New Kind of Wellness - Log in to the Well onTarget Portal Today! Well onTarget is designed to give you the support you need to make healthy choices. All while rewarding you for your hard work.

BlueCross BlueShield of Montana

Well onTarget®

How to access Well onTarget:

1. Log in to bcbsmt.com/member
2. Click on the **Well onTarget** link to access the portal

Once you are logged in, you will find personalized tools and resources to help you plan your health and wellness path.

Here are some exciting benefits of the Well onTarget program:

Health Assessment

You can take the Health Assessment to learn more about your health and receive a personal wellness report.

Take Your Health Assessment & Earn 2,500 Blue Points!

Blue Points

Earn points by regularly participating in a range of healthy activities. You can then redeem your points for popular health and wellness merchandise and services.

Redeem your points in the online Shopping Mall for... Apparel, Books, Health & Personal Care, Jewelry, Electronics, Music and Sporting Goods

Tools & Trackers

Interactive tools help keep you on course while making wellness fun. You can track all your nutrition and fitness data in one place, and track your fitness activity using a Fitbit.

Tracking what you eat and how much you work out each day can help you reach your wellness goals.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

For a Healthy Life!

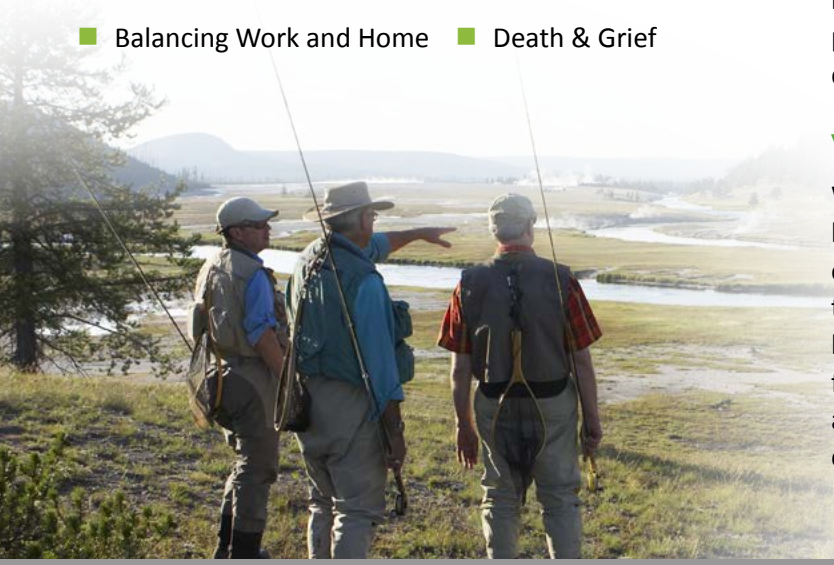
The EAP provides confidential assessment, counseling and referral services for issues that are important to you and your family.

Our Employee Assistance Program (EAP) is provided through MINES & Associates. This program is available to you and your household family members at NO COST.

The EAP is designed to assist you in obtaining the correct professional help for your concerns. When you contact the EAP, a staff member will schedule an appointment for you with a therapist to assess your situation, advise you of alternatives for help or provide short term counseling, if appropriate. These appointments will be scheduled at mutually convenient times and may be set up as an office visit or over the telephone depending on your preference.

The EAP can help with the following issues, among others:

- Stress
- Depression
- Family Issues
- Marital and Relationship Issues
- Balancing Work and Home
- Parenting Issues
- Alcohol and Drug Dependency
- Child or Elder Care
- Troubled Adolescents
- Death & Grief



You and each member of your household are eligible for up to 5 face-to-face counseling sessions per year, per issue – FREE OF CHARGE!

If you should need longer term care, MINES will assist you in identifying a long term counselor that will best fit your needs. It may be possible that the counselor you've seen during your short term sessions would be available for long term care as well.

Legal/Financial Services

In addition to the free face-to-face counseling sessions, each member is entitled to one initial 30-minute office or telephone consult per separate legal matter at no cost with a network attorney. You also have financial counselors to advise you via telephonic consultations that are limited between thirty and sixty minutes per issue. Other tools under the MINES financial/ legal benefit include mediation, tax consultation and preparation, and "Do it Yourself" legal forms and document preparation.

Work/Life Concierge Services

We know how difficult balancing work and family can be. For everything from finding the right dependent care providers for your children or elderly loved ones, to knowing where to find a good pet sitter, the work/ life concierge services are here to help. Call into MINES for unlimited referral services to help you plan in advance and find the right provider for your needs and circumstances.

MINES & ASSOCIATES
A National Business Psychology Firm

How to Access the EAP

1-800-873-7138

Call any time, 24 hours a day, seven days a week, including holidays.

Mines & Associates will check your eligibility and your enrolled family member's eligibility using the ***employee's*** name, date of birth and Company name (Stillwater Mining Company).

www.minesandassociates.com

User Name: **stillwater**

Password: **employee**

The EAP website offers information on a number of valuable resources.

The EAP is voluntary and CONFIDENTIAL; only your EAP counselor will know you have called.

FLEXIBLE SPENDING ACCOUNTS (FSA)

For a Healthy Life!

Flexible Spending Accounts (FSAs) are a great way to lower your taxes and increase your take-home pay!

Connect Your Care

You may participate in two different FSAs administered through ConnectYourCare — the Health Care FSA and/or the Dependent Care FSA. These accounts are separate — you may choose to participate in one, both, or neither. You do not have to participate in the Sibanye-Stillwater Health Plan to be eligible for the Health Care FSA.

What is a FLEX Spending Account?

A Flexible Spending Account (FSA) is a tax-favored program that lets you set aside money from your paycheck on a ***pre-tax*** basis to pay for eligible health care and/or dependent care expenses. Because that portion of your income is not taxed, you end up with more money in your pocket!

Why Should I Participate?

The FSAs can save you up to 15% - 35% in taxes on each dollar that you spend. Also, the Dependent Care FSA may save you more in taxes than the day-care tax credit (filed with your federal income tax return). If you spend over $100 annually on eligible health care and/or dependent care expenses, you might benefit from participating in the FSAs.

Here's an example of how participation in an FSA can save you money:

Example	Estimated Expenses
Estimated Qualifying Expenses	
Health Care	$1,000
Daycare	$3,600
Total Annual FSA Election	$4,600
Total Estimated Annual Tax Savings*	**$1,272**

**Tax Savings are estimated based on Federal & State Tax at 20%, plus Social Security and Medicare.*

How Do FSAs Work?

1. Carefully estimate what you'll need for out-of-pocket health care and/or dependent care expenses for the 2018 calendar year (or portion thereof depending on your effective date of coverage), subject to the plan limit.
2. Your contributions will be deducted from your paycheck in equal installments throughout the 2018 calendar year. To calculate this amount, divide your total estimated expenses the number of paychecks you'll receive in 2018. This is the amount that will be deducted from each paycheck and held by Sibanye-Stillwater, without interest.
3. As you incur eligible health care and/or dependent care expenses throughout the year, submit a claim form and the required documentation to ConnectYourCare. Your claim will be processed and you will be reimbursed from your account. Your reimbursement checks will be mailed directly to your home address or you may elect Direct Deposit. For health care expenses, you may also use your ConnectYourCare Debit Card to pay at the point of sale. You will not be paying out of pocket so there's no need to fill out a claim form, however, you must retain all of your receipts to substantiate your purchases.

HOW TO SUBMIT A CLAIM

1. Fill out an FSA claim form and attach proper documentation and fax or email it to ConnectYourCare. Click here for the claim form and instructions.
2. For health care expenses, use your ConnectYourCare Debit Card.

FLEXIBLE SPENDING ACCOUNTS (continued)

For a Healthy Life!

Health Care FSA

For 2018, you may contribute **up to $2,650** in pre-tax dollars to cover eligible health care expenses. **The entire annual amount you set aside is available to use on your effective date of coverage.** The Health Care FSA allows you to pay for a variety of health care expenses that are not reimbursed by any other source and are not claimed on your income tax return, such as copayments, coinsurance, and deductibles. You may be reimbursed for expenses incurred by you, your spouse, and your children under age 26.

What are eligible health care expenses?

We often get questions regarding various health care services and whether or not they are reimbursable from someone's Flexible Spending Account. There is a handy website where you can look up medical services and supplies to determine if they qualify for reimbursement.

- Go to www.fsafeds.com
- Click on Quick Links
- Select Eligible Expenses Juke Box

The letters of the alphabet will show up across the screen. Click on the **first letter of the service or item in question**, i.e. C for crutches.

Here are just a few examples of eligible health care expenses:

- Deductibles, copays and coinsurance for medical, dental and vision care
- Orthodontia services
- Eyeglasses, contact lenses, contact lens solutions and supplies
- Prescription medications
- Laser eye surgery (LASIK)
- Over-the-counter (OTC) health-related supplies that ***do not require*** a prescription from your doctor such bandages/wraps, diabetic supplies, contact lens solution/supplies, reading glasses, thermometers and catheters.
- Over-the-counter (OTC) drugs that ***require*** a written prescription (Rx) from your doctor such as pain relievers, cold and flu remedies or allergy and sinus products.

Dependent Care FSA

For 2018, you may contribute **up to $5,000** in pre-tax dollars to cover eligible dependent care expenses. **Exception:** If you are married and file separate tax returns, your maximum contribution is $2,500. **Unlike the Health Care FSA, your Dependent Care FSA funds are available as they accumulate through payroll deductions.**

To qualify as an expense under a Dependent Care FSA, the expense must be related to dependent care that enables an individual or married couple to remain gainfully employed or look for work. If married, your spouse must work or be a full-time student.

Following are some examples of eligible dependent care expenses:

- Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or day care center.
- Care for any member of your household who is physically or mentally incapable of caring for him/herself and qualifies as your tax dependent.
- Care for an elderly dependent family member who lives with you and qualifies as your tax dependent.

For a Healthy Life!

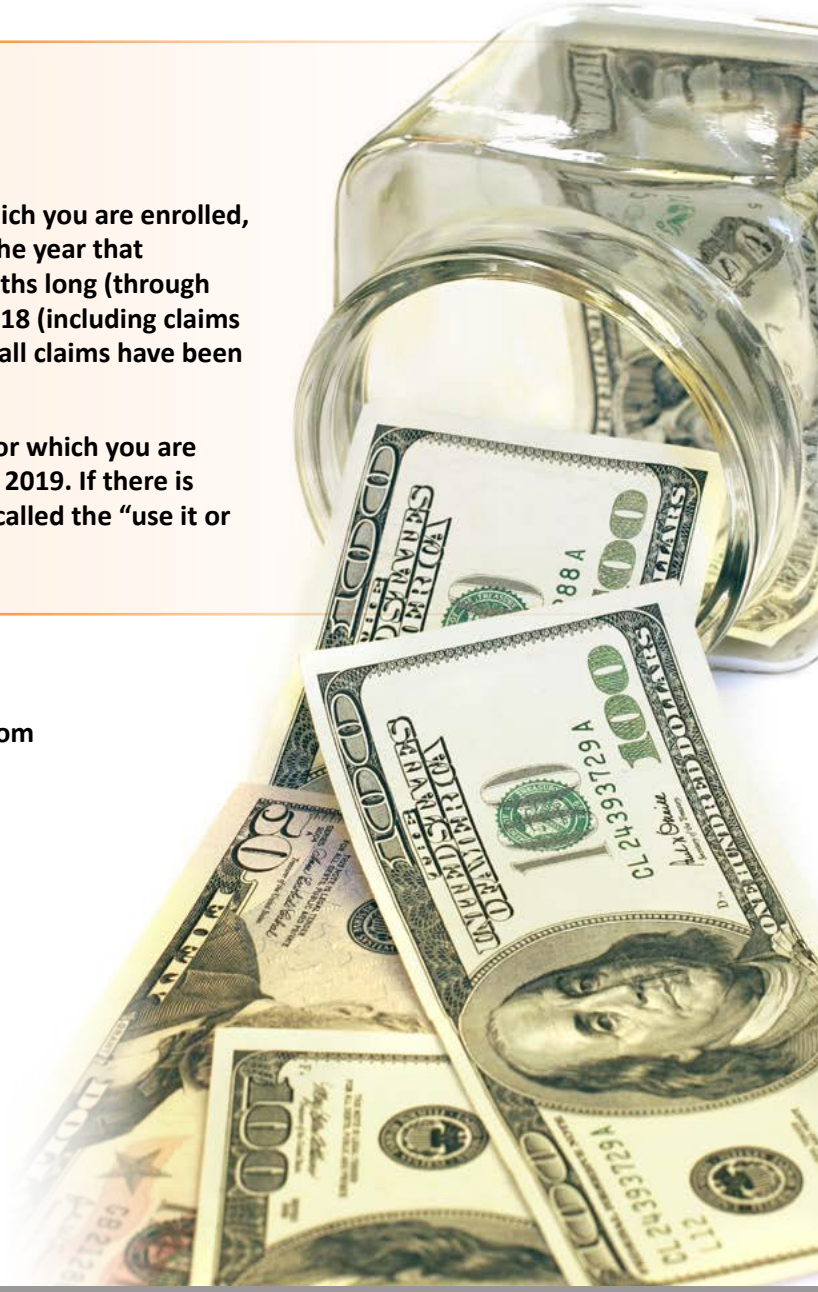
PLAN YOUR FSA CONTRIBUTIONS CAREFULLY!

USE-IT-OR-LOSE-IT!

Because of the tax advantages FSAs offer, the IRS places restrictions on their use:

HEALTH CARE FSA — Your eligible expenses must be incurred during the calendar year for which you are enrolled, including the FSA Grace Period. The Grace Period is an extended period of time at the end of the year that provides more time for you to use any remaining funds in your FSA. The Grace Period is 2 months long (through February of the following year). The claims filing deadline for health care claims incurred in 2018 (including claims incurred during the Grace Period) is April 30, 2019. If there is money left in your account after all claims have been processed, you lose the balance. This is called the "use it or lose it" rule.

DEPENDENT CARE FSA — Your eligible expenses must be incurred during the calendar year for which you are enrolled. The claims filing deadline for dependent care claims incurred in 2018 is February 28, 2019. If there is money left in your account after all claims have been processed, you lose the balance. This is called the "use it or lose it" rule.



FSA Reminders

- **You must enroll each year to participate. Your FSA election will NOT automatically carry over from one year to the next. To participate, you must enroll each year during Open Enrollment.**
- **Keep all receipts.**
- **Your pre-tax contribution(s) will be deducted from your paycheck in equal installments throughout the calendar year.**
- **You cannot stop or change the amount you contribute during the year, unless you experience a qualifying Change in Status (see page 5 for details).**
- **Transfers from one account to the other are not allowed.**
- **Expenses incurred before your effective date are not eligible. Expenses incurred after your participation ends are not eligible.**
- **Once enrolled, you can log on to www.connectyourcare.com to manage your account(s) and view your ConnectYourCare Debit Card activity and balance.**

RETIREMENT – 401(K)

For a Healthy Life!

Simply put, the 401(k) Plan is one of the best ways to save for retirement — and save on taxes in the process.

Prudential

You are eligible to participate in the Company's 401(k) Retirement Savings Plan 30 days after your date of hire. The 401(k) Plan is designed to help you save for retirement and reduce your current tax liability. Saving is made easy by automatic payroll deduction into the investment options of your choice.

AUTOMATIC ENROLLMENT

To get your retirement savings off to a good start, Sibanye-Stillwater will automatically enroll you in the 401(k) plan at a contribution rate of 6% of your eligible compensation (you may choose a different percentage or decline to participate after this Automatic Enrollment).

To access your account, log on to the participant website at: http://stillwater.retirepru.com/ or call 1-877-778-2100

Contributions

Employee Pre-Tax	Up to 60% of eligible compensation each paycheck
Employee After-Tax	Up to 10% of eligible compensation each paycheck
Rollovers	Up to 100% of eligible contributions from a prior qualified retirement plan
Employer Match	**150% on first 4% and 100% on next 2%**

Vesting

Employee Pre-Tax	100% immediately
Employee After-Tax	100% immediately
Rollovers	100% immediately
Employer Match	100% after one year of service

IRS Limits for 2018: The IRS imposes limits, which must be adhered to and should be considered by all employees, especially those determined to be "highly compensated" employees. The following limits reflect those that are in effect for 2018. Limits are adjusted by the IRS annually.

Compensation Limit	$275,000
Employee Pre-Tax Dollar Limit	$18,500
Catch-up Contributions (Age 50+)	$6,000
Total Contributions Dollar Limit	$55,000 annually (pre-tax,after-tax & employer match)

Highly Compensated Employees (generally employees who earn more than $120,000 annually) are subject to non-discrimination testing limits. Accordingly, all employees who anticipate earning $120,000 or more should consult with the Columbus Human Resources Department annually to avoid unnecessary refunds and adverse tax consequences.

FINANCIAL WELLNESS

For a Healthy Life!

Sibanye-Stillwater realizes that it's important to have a reliable and trustworthy source at your disposal to help you make the best decisions for your financial future. That's why we are pleased to introduce our Financial Wellness program, provided in partnership with the leading unbiased financial education firm in the country, Financial Finesse.

FINANCIAL FINESSE

Financial Helpline

You and your family can get questions answered on any financial topic at NO COST to you. The Financial Helpline provides you with ongoing support so that you can continue to build out your financial plan and ensure that you are making the best decisions about your life goals. This benefit provides you with the opportunity to talk one-on-one with a completely unbiased Certified Financial Planner™ professional who you can trust has only your best interest in mind.

One call can help you choose the right path!

Call the Financial Helpline for answers and ongoing support on virtually any financial concern you may have.

1-888-450-2881 (toll-free)

Monday - Friday, 7:00 A.M. – 6:00 P.M. MDT

- You will speak with a Certified Financial Planner when you call the Helpline.
- All calls are confidential.
- No sales pitch, they have no product or service to sell.
- No limit to the number of questions you can ask.
- No limit to the number of times you can call.
- Questions are welcome on any financial topics/matters.
- Your family members may also call the financial helpline. They will simply need to identify themselves as being with the Sibanye-Stillwater plan, and provide the name of the Sibanye-Stillwater employee.

Financial Planning Workshops

You and your family can access financial planning workshops at NO COST to you. In these 90 minute workshops, you'll get the most relevant guidance and information to deal with the specific issues you and your family face so that you can proactively plan for all of your financial goals. Each workshop is highly interactive, providing participants with a hands-on approach so that you get the most from your experience. You'll also develop a personalized action plan to immediately start working toward your goals.

- Workshops are offered quarterly and taught by Certified Financial Planners.
- You can bring a family member to attend a class with you.
- For more information on when the next workshops will be offered, contact HR or visit the Sibanye-Stillwater Family website at www.stillwaterfamily.org.

LIFE INSURANCE

For a Healthy Life!

Principal

Life Insurance coverage provides your family or beneficiary(ies) with a financial benefit in the event you pass away.

Basic Life Insurance

As a benefit-eligible employee you are provided with Basic Life insurance at **NO COST** to you.

- Basic Life benefit amount is equal to your annual compensation rounded to the next higher $1,000, multiplied by 2, up to a maximum of $300,000 ($10,000 minimum).
- Benefit amount reduces by 50% on the first day of the calendar year following or coincident with the date you reach age 70.
- If you become terminally ill, you may be eligible to receive up to 75% of your Life insurance benefit, up to a maximum of $250,000.

Voluntary Life Insurance

In addition to the Basic Life benefit provided by Sibanye-Stillwater, you may also elect additional Voluntary Life coverage for yourself and your eligible family members. You pay 100% of the premium costs through convenient ***after-tax*** payroll deductions. **Voluntary Life can be changed at any time during the year!**

VOLUNTARY LIFE COVERAGE OPTIONS	
Employee	• Coverage is available in increments of $10,000 up to a maximum of $500,000* • Guaranteed Issue: a health statement is required for amounts greater than $200,000
Spouse	• Coverage is available in increments of $5,000 up to a maximum of $50,000 (not to exceed 100% of employee coverage)* • Guaranteed Issue: a health statement is required for amounts greater than $25,000
Child(ren)	• Choose from $5,000, $10,000 or $15,000 (not to exceed 100% of employee coverage)

*Benefits reduce by 50% on the first day of the calendar year following or coincident with the date the employee or spouse reaches age 70.

VOLUNTARY LIFE MONTHLY RATES	
Employee & Spouse Rates per $1,000 of Coverage	
Age	**Rate**
Under 30	$0.105
30 – 39	$0.124
40 – 44	$0.228
45 – 49	$0.342
50 – 54	$0.589
55 – 59	$1.168
60 – 64	$1.718
65 – 69	$2.403
70+	$3.771
Rate is based on your age as of January 1 of the year your coverage becomes effective. Your age will be updated on January 1 each year.	
Child Rates	
Benefit Amount	**Rate**
$5,000	$1.00
$10,000	$2.00
$15,000	$3.00
Rate covers all your eligible children, regardless of family size. Children up to age 26 are eligible for coverage, regardless of student status.	

Naming Your Beneficiary(ies)

Your beneficiaries are the people you name to receive your Life and AD&D benefit in the event of your death. It is important that you keep up-to-date beneficiary information on file with Human Resources. You cannot name a new beneficiary without completing a new designation form. You may change your beneficiary at any time. **NOTE:** A divorce or legal separation will not automatically affect a beneficiary designation, so we strongly encourage you to periodically review your beneficiary election(s) to ensure it accurately reflects your wishes.

Periodic Benefit Increase

Each year during Open Enrollment, you can increase your Voluntary Life insurance by **$10,000** and your spouse's by **$5,000** up to the Guaranteed Issue amount – with **no health information needed**.

If you need additional coverage beyond the policy's Guaranteed Issue amount, you will need to provide a health statement (proof of good health). Once you provide proof of good health, you can continue to increase your coverage each year by one increment ($10,000 employee / $5,000 spouse) up to the policy's maximum benefit – with **no additional health information needed**.

If you have a qualifying Change in Status such as marriage, birth of a child or adoption, you are guaranteed coverage up to the Guaranteed Issue amount if that coverage request is made within 31 days of the qualifying Change in Status. Coverage amounts that require a health statement must be approved by Principal prior to coverage going into effect.

AD&D INSURANCE

For a Healthy Life!

Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot, or eye). In the event you pass away due to an accident, both the Life and the AD&D benefit would be payable.

Cigna

Basic AD&D Insurance

As a benefit-eligible employee you are provided with Basic AD&D Insurance at NO COST to you.

- Basic AD&D benefit amount is equal to your annual compensation rounded to the next higher $1,000, multiplied by 2, up to a maximum of $300,000 ($10,000 minimum).
- Benefit amount reduces by 50% on the first day of the calendar year following or coincident with the date you reach age 70.

Voluntary AD&D Insurance

You may also elect additional Voluntary AD&D coverage for yourself and your family. You pay 100% of the premium cost through convenient *after-tax* payroll deductions.

- **Employee Option #1:** Choose a coverage amount equal to your annual compensation rounded to the next higher $1,000 and multiplied 1, 2, 3, 4, or 5 times, up to a maximum of $500,000 ($10,000 minimum).
- **Employee Option #2:** Coverage amount equals a flat $50,000. Your cost is $3.50 per month.
- **Family Option:** If you elect coverage for yourself and select the Family Option, your spouse's benefit amount will be 40% of your amount or 50% if you have no dependent children. Each of your covered children's benefit amount will be 10% of your amount or 15% if you have no eligible spouse. The cost for the Employee + Family Option is $0.11 per $1,000 per month.
- Coverage is guaranteed, no medical questions asked, regardless of when you enroll.
- Benefit amount reduces by 50% on the first day of the calendar year following or coincident with the date you reach age 70.

AD&D Schedule of Benefits (applies to both Basic and Voluntary coverage): If an injury results in death or dismemberment while you are insured, benefits will be paid for loss of:

Loss	% of AD&D Benefit Amount
Life	100%
Two or More Hands or Feet	100%
Sight of Both Eyes	100%
Speech and Hearing (in both ears)	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Uniplegia	25%
One Hand or Foot	50%
Sight in One Eye	50%
Severance and Reattachment of One Hand or Foot	50%
Loss of Speech	50%
Loss of Hearing (in both ears)	50%
Loss of Thumb and Index Finger of the Same Hand	25%
Loss of all Four Fingers of the Same Hand	25%
Loss of all the Toes of the Same Foot	20%
Coma	1% (monthly benefit)

Additional AD&D Benefits

- **Seat Belt** (Basic and Voluntary AD&D): An additional benefit equal to 10% of your AD&D benefit up to $50,000 will be paid to your beneficiary if you pass away in an auto accident and were wearing a seat belt.
- **Airbag** (Basic and Voluntary AD&D): An additional benefit equal to 10% of your AD&D benefit up to $50,000 will be paid to your beneficiary if you pass away in an auto accident and were protected by an airbag.
- **Spouse Education** (Voluntary AD&D only): An additional benefit up to $3,000 is available to help pay for eligible education expenses of your spouse if you pass away in a covered accident.
- **Child Education** (Voluntary AD&D only): An additional benefit equal to 5% of your AD&D benefit up to $5,000 is available to help pay for eligible education expenses of your qualifying child if you pass away in a covered accident.
- **Child Care** (Voluntary AD&D only): An additional benefit equal to 5% of your AD&D benefit up to $5,000 is available to help pay for eligible day care expenses of your qualifying child if you pass away in a covered accident.

SECURE TRAVEL

For a Healthy Life!

The Secure Travel program provides a wide array of travel assistance services when you are traveling 100 miles or more away from home on vacation or company business.

Cigna

Secure Travel is part of the AD&D plan and is provided at **NO COST** to you.

Pre-trip planning

These services include:

- Immunization requirements
- Visa and passport requirements
- Foreign exchange rates
- Embassy/consular referrals
- Travel/tourist advisories
- Temperature and weather conditions
- Cultural information

Emergency medical assistance

Cigna Secure Travel will pay to arrange:

- Referrals to physicians, dentists and medical facilities
- Emergency medical evacuation (medically necessary transport to the closest adequate facility) and repatriation (medically necessary transport back home or to a medical facility near your home)
- Repatriation of mortal remains
- Travel of a dependent child (under age 16) who is left unattended as a result of your serious illness or injury
- Round-trip (economy class) transportation for a family member if you're expected to be hospitalized for more than 10 days

Help with the unexpected

In time of emergency, Cigna Secure Travel can provide:

- Prescription refill assistance*
- New travel plans for a companion who lost existing arrangements due to delays caused by your emergency
- Up to $10,000 cash advance for payment of emergency medical services*
- Emergency cash – advance of up to $1,500*
- Emergency changes to travel plans
- Emergency message center
- Assistance with lost or stolen items, including luggage, prescriptions and other personal belongings*
- Legal referrals to local attorneys, embassies and consultants*
- Translation and interpretation assistance
- 24-hour multilingual assistance
- Advancement of bail*

How to reach Secure Travel

- From the U.S. & Canada: **1-888-226-4567**
- From all other locations: **1-202-331-7635** (call collect)
- Policy# OK968037
- Group# 57

Emergency services must be coordinated through Cigna Secure Travel. Services coordinated outside of this program may not be eligible for payment.

** You are responsible for repaying these funds to Cigna Secure Travel as this program does not cover these expenses.*

DISABILITY COVERAGE

For a Healthy Life!

Disability Insurance provides benefits that replace part of your lost income when you become unable to work due to a covered injury or illness.

Principal

Short Term Disability

After you complete one year of continuous active full-time service, you are automatically provided with Short Term Disability coverage at **NO COST** to you. This program is designed to assist employees who are unable to work due to a **non-occupational** illness or injury that renders them disabled.

- Your weekly benefit amount is based on years of continuous service with Sibanye-Stillwater as follows:

Years of Continuous Service	Benefit Amount
Less than one year	No benefit
One or more years	100% of your basic weekly earnings

- You must be disabled for 40 working hours, or 5 scheduled shifts, whichever is less, before benefits begin. You are required to use your accrued sick days before benefits begin.
- You must be under the care of a doctor and deemed unable to perform at least one of the substantial duties of your Own Occupation as defined in the Plan Document.
- Benefits will be paid until you are no longer disabled, or up to a maximum of 26 weeks. At that point, your Long Term Disability benefits will begin, should your disability continue.
- If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
- If you become disabled and participate in the vocational rehabilitation program, which offers services that help you return to work and ability, you will be eligible for a weekly benefit increase of 5%.

Long Term Disability

After you complete one year of continuous active full-time service, you are automatically provided with Long Term Disability coverage at **NO COST** to you. This program is designed to assist employees who are unable to work due to an **occupational** or **non-occupational** illness or injury that renders them disabled.

- Your monthly benefit amount is 60% of your basic monthly earnings, up to a maximum of $7,000, subject to reduction by deductible sources of income as defined in the Plan Document.
- You must be disabled for 180 days before benefits begin. Benefits become payable on the 181st day of disability.
- For the first 2 years of disability, you must be under the care of a doctor and deemed unable to perform the majority of the substantial duties of your Own Occupation as defined in the Plan Document. After 2 years, you must be under the care of a doctor and deemed unable to perform all of the substantial duties of Any Occupation as defined in the Plan Document.
- Benefits will be paid until you are no longer disabled, or up to your Social Security Normal Retirement Age. If you become disabled at age 62 (and older), the benefit period will be based on a reduced duration schedule.
- If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
- Pre-existing conditions will not be covered until you are enrolled in the plan for 12 months.
- If you pass away while receiving long-term disability benefits, your benefits will be provided to your beneficiaries for a period of time after your death.
- For disabilities related to drug and alcohol abuse and mental health, benefits are available for up to 24 months.

SUPPLEMENTAL BENEFITS

For a Healthy Life!

Sibanye-Stillwater offers supplemental benefits through Aflac as part of our benefits package. Coverage is available to you and your eligible family members at affordable group rates.

Aflac

Dependent children are covered under your Aflac policy until age 19 (or 23 if a full-time student). You pay 100% of the costs through convenient *pre-tax* payroll deductions.

Aflac benefits can only be changed during Open Enrollment or if you have a qualifying Change in Status.

Accident Indemnity Advantage℠

This Plan is designed to help cover the expenses associated with an accidental injury. It pays you directly, unless you assign the benefits, regardless of any other insurance you may have. Plan benefits include: accident emergency treatment, initial accident hospitalization, rehabilitation, physical therapy and more.

MONTHLY COST:

Coverage Tier	Plan "A" Office/ Clerical	Plan "C" Non-Office/ Clerical
Individual	$21.58	$28.86
Employee & Spouse	$30.56	$37.84
Single Parent	$34.98	$42.38
Family	$45.50	$52.78

Maximum Difference® Cancer Indemnity Insurance

This Plan is designed to help cover the expenses associated with cancer. It pays you directly, unless you assign the benefits, regardless of any other insurance you may have. Plan benefits include: initial treatment, injected chemotherapy, oral chemotherapy, radiation, hospital confinement, surgical/anesthesia, home health care, plus much more.

MONTHLY COST:

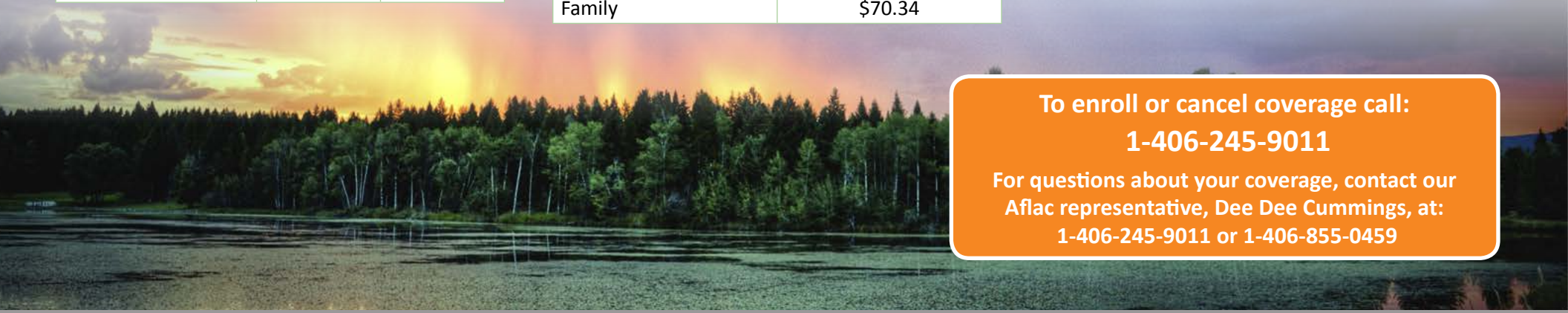
Coverage Tier	Rate
Individual	$40.18
Employee & Spouse	$70.34
Single Parent	$40.18
Family	$70.34

Hospital Protection Plan 3 (Hospital Confinement)

This Plan is designed to help cover the expenses associated with hospital confinement. It pays you directly, unless you assign the benefits, regardless of any other insurance you may have. Plan benefits include: hospital confinement, rehabilitation unit, invasive diagnostic exams, surgical, ambulance and more.

MONTHLY COST:

Coverage Tier	Rate
Individual	$58.64
Employee & Spouse	$98.16
Single Parent	$79.04
Family	$103.62



To enroll or cancel coverage call:

1-406-245-9011

For questions about your coverage, contact our Aflac representative, Dee Dee Cummings, at: 1-406-245-9011 or 1-406-855-0459

OTHER VALUABLE BENEFITS

For a Healthy Life!

Paid Leaves

Upon completion of your probationary period, you are eligible for the following paid leaves per Sibanye-Stillwater policy and with management approval:

- Vacation
- Sick/Personal leave
- Bereavement leave
- Jury/Witness duty

Additionally, Sibanye-Stillwater complies with Federal and State laws governing leaves of absence. Family Medical Leave and Military Leave are offered without pay to employees whose circumstances match the provisions of the law.

Holidays

The following days shall be considered paid holidays per Sibanye-Stillwater policy.

- New Year's Day
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve
- Christmas Day
- Personal Holiday*

*Any day during the calendar year which you elect to take with advance notice to, and approval from the Company, per Sibanye-Stillwater Policy.

IMPORTANT NOTICES

For a Healthy Life!

Medicare Part D

If you or your eligible family members are eligible for 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 Sibanye-Stillwater 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.

Important things you need to know about your current coverage and Medicare's Rx 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. Sibanye-Stillwater has reviewed its current prescription drug coverage offered under its Health Plan and has determined that coverage is, on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are therefore considered Creditable Coverage.

If you are enrolled in the Medical Plan, your existing coverage is Creditable Coverage. This means 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 coverage, through no fault of your own, OR you decide to drop you current Sibanye-Stillwater coverage, 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, and keep your current coverage, your current coverage will not be affected (see page 14 for a summary of the Rx benefits). If you decide to join a Medicare drug plan, and drop your current coverage, you and your eligible family members will be able to get the coverage under the medical benefit options in force at the next Open Enrollment period, assuming you meet eligibility requirements at that time.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? If you drop or lose your current Creditable Coverage 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. In addition, starting with the end of the last month that you were first eligible to join a Medicare drug plan, 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 October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage: Contact Human Resources. 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 through Sibanye-Stillwater changes. You also may request a copy of this notice at any time.

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.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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).

Health Insurance Marketplace Coverage Options and Your Health Coverage

Among the many health care reform changes directed under federal law, special rules require employers to disclose information about health plan options available to employees through the Health Insurance Marketplace. While we cannot provide you with assistance in evaluating your options for exchange coverage or the potential penalties under the law, the government agencies will have some educational materials and sources for additional information.

PART A: General Information

When key parts of the health care law took effect in 2014, there was established a new way to buy health insurance: 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 new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 2017 for coverage starting as early as January 1, 2018.

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 9.5% 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 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 Sibanye-Stillwater Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.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.

Health Insurance Marketplace Coverage Options and Your Health Coverage (continued)

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.

Here's the employer information you'll enter when you visit www.HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

3. Employer name **Sibanye-Stillwater**	4. Employer Identification Number (EIN) **81-0480654**	
5. Employer address **536 East Pike, PO Box 1330**	6. Employer phone number **1-406-322-8930**	
7. City **Columbus**	8. State **MT**	9. ZIP code **59019**
10. Who can we contact about employee health coverage at this job? **Sibanye-Stillwater – Human Resources**		
11. Phone number (if different from above)	12. Email address **N/A**	

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

As your employer, we offer a health plan to:

☐ All employees

☑ Some employees. Eligible employees are:
Active full-time employees regularly scheduled to work 30 or more hours per week.

With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

- Legal Spouse
- Your natural child, stepchild, or adopted child, or other child for whom a court holds you responsible
  - Children are eligible from birth up to age 26, whether or not they're living apart from you, dependent on you for support, a student, married, or eligible for other coverage from their own job (or spouse's job).
  - Children who are physically or mentally incapable of self-support may continue on your Sibanye-Stillwater Health coverage beyond the normal age limit if the disability continues. The child must already be covered under the plan. You may be asked to provide certification of the child's disability annually.

☑ 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, www.HealthCare.gov will guide you through the process.

Medicaid and the Childrens Health Insurance Program (CHIP)

If you are eligible for health coverage, but are unable to afford the premiums, some states, including Montana, have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your eligible family members are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your eligible family members are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your family members might be eligible for either of these programs, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your eligible family members are eligible for premium assistance under Medicaid or CHIP, you and your eligible family members are eligible to enroll in the Company's health plan – as long as you and your eligible family members are eligible, but not already enrolled in the Company's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Special Open Enrollment Rights for Certain Individuals under Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, in the future you may be able to enroll yourself and your dependents in the Sibanye-Stillwater Health Plan provided you request enrollment within 31 days after your other coverage ends.

Women's Health and Cancer Rights Act (WHCRA)

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

Notice Regarding Wellness Program

Sibanye-Stillwater ("the Company") provides a voluntary wellness program to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program you, and your spouse, will be asked to complete a voluntary biometric screening, which will include measurement of height, weight, Body Mass Index, blood pressure and a blood test for metrics such as cholesterol, glucose and other potential health risks. Sibanye-Stillwater contracts with a third party to administer the biometric screenings.

You and/or your spouse are not required to participate in the biometric screening or other medical examinations. However, employees and spouses who choose to complete the biometric screening will receive a financial incentive. Only employees and spouses who participate will receive the financial incentive. The participation of employees and spouses will be treated separately.

From time to time, additional incentives, such as gift cards and other monetary and non-monetary awards, may be available for employees and spouses who participate in certain health-related activities or achieve certain health outcomes. If you, and/or your spouse, are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you and/or your spouse may be entitled to a reasonable alternative standard. You or your spouse may request a reasonable alternative standard by contacting Human Resources.

The results from your biometric screening will be used to provide information to help you understand your current health and potential risks, and may also be used to offer services through the wellness program, such as ongoing health education. Participants are strongly encouraged to share results of their biometric screening with their doctors.

Protections from Disclosure of Medical Information

Sibanye-Stillwater and its partners are required by law to maintain the privacy and security of your personally identifiable health information. The Company may only use aggregate information to design wellness programs based on our population's identified health risks. Participants' personal health information will not be disclosed to the Company or released publicly, except as necessary to respond to a request for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Additionally, medical information that personally identifies participants will not be provided to supervisors or managers and may never be used to make decisions regarding employment.

Participants' health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program. Participants will not be asked or required to waive the confidentiality of their health information as a condition of participating in the wellness program or receiving an incentive.

Anyone who receives information for purposes of providing services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive participants' personally identifiable health information is Western Health Screenings, which is responsible for administering biometric screenings.

In addition, medical information obtained, if any, through the wellness program will be maintained separately from personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event there is a data breach involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Sibanye-Stillwater Human Resources.

Wellness Program Disclosure Notice of the Availability of a Reasonable Alternative Standard

Sibanye-Stillwater is committed to helping employees and their families achieve their best health. Rewards for participating in a wellness program are available to all employees, and in some cases, to their spouses.

If you, and/or your spouse, think you might be unable to meet a standard for a reward under this wellness program, either of you might qualify for an opportunity to earn the same reward by different means. Contact Sibanye-Stillwater Human Resources and we will work with you or your spouse to identify a wellness program standard with the same reward that is appropriate for your health status.

Wellness Incentives

Employees who participate in Sibanye-Stillwater wellness program may receive a credit that can be used to offset the cost of benefits. The wellness credit may be subject to change based on your or your spouse's participation in the Company's wellness program. Sibanye-Stillwater may automatically apply or discontinue the wellness credit based on your or your spouse's compliance with the wellness program's requirements in effect from time to time.

Notice of Privacy Practices

HIPAA privacy rules require that health plans, or their insurers, distributes a notice to participants explaining their privacy rights as group health plan participants at least every three years. HIPAA also requires that plans give the notice to new participants and to redistribute the notice if it is revised.

Sending the following notice annually fulfills the requirement and might be easier than remembering to send it every three years.

Note: In 2013, HIPAA protections were expanded in important ways, including significant changes to the notice used to explain HIPAA rules governing the group health plan

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

Sibanye-Stillwater
Bargaining Unit Health Plan &
Employer Health Benefit Plan
Notice of Privacy Practices
Date: June 13, 2017

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights with respect to your Protected Health Information ("PHI"), including the right to know how your PHI may be used by a group health plan.

This Notice of Privacy Practices ("Notice") covers the following group health plans (collectively referred to as the "Plan"):

- Medical
- Dental
- Vision
- Health FSA
- EAP

The Plan is required by law to maintain the privacy of your PHI and to provide this Notice to you pursuant to HIPAA. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, health care operations, or for any other purposes that are permitted or required by law. This Notice also provides you with the following important information:

- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan's Privacy Officer and/or to the Secretary of the Office of Civil Rights of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

PHI is health information (including genetic information) in any form (oral, written, electronic) that:

- Is created or received by or on behalf of the Plan;
- Relates to your past, present or future physical or mental condition, or the provision of health care services to you, or the payment for those health care services; and
- Identifies you or from which there is a reasonable basis to believe the information can be used to identify you.

Health information your employer receives during the course of performing non-Plan functions is not PHI. For example, health information you submit to your employer to document a leave of absence under the Family and Medical Leave Act is not PHI.

Section 1. USES AND DISCLOSURES OF YOUR PHI

Under HIPAA, the Plan may use or disclose your PHI under certain circumstances without your consent, authorization or opportunity to agree or object. Such uses and disclosures fall within the categories described below. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

General Uses and Disclosures

Treatment. The Plan may use and/or disclose your PHI to help you obtain treatment and/or services from providers. Treatment includes the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist soat the orthodontist may ask for your dental x-rays from the treating dentist. The Plan may also disclose information about your prior prescriptions to a pharmacist to determine if any medicines contraindicate a pending prescription.

Payment. The Plan may use and/or disclose your PHI in order to determine your eligibility for benefits, to facilitate payment of your health claims and to determine benefit responsibility. Payment includes, but is not limited to billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. The Plan may also disclose your PHI to another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate payment of benefits.

Health Care Operations. The Plan may use and/or disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan and include, but are not limited to, conducting quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, underwriting, premium and other activities relating to Plan coverage. It also includes cost management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general Plan administrative activities. For example, the Plan may use your PHI in connection with submitting claims for stop-loss coverage. The Plan may also use your PHI to refer you to a disease management program, project future costs or audit the accuracy of its claims processing functions.However, the Plan is prohibited from using or disclosing PHI that is an individual's genetic information for underwriting purposes.

Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide such services, the Business Associates will receive, create, maintain, use and/or disclose your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide pharmacy benefit management services. However, Business Associates will receive, create, maintain, use and/or disclose your PHI on behalf of the Plan only after they have entered into a Business Associate agreement with the Plan and agree in writing to protect your PHI against inappropriate use or disclosure and to require that their subcontractors and agents do the same.

Plan Sponsor. For purposes of administering the Plan, the Plan may disclose your PHI to certain employees of Sibanye-Stillwater. However, these employees will only use or disclose such information as necessary to perform administration functions for the Plan or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Required By Law. The Plan may disclose your PHI when required to do so by federal, state or local law. For example, the Plan may disclose your PHI when required by public health disclosure laws.

Health or Safety. The Plan may disclose and/or use your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of another individual or the public. Under these circumstances, any disclosure will be made only to the person or entity able to help prevent the threat.

Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI without your consent, authorization or opportunity to agree or object. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

Public Health Activities. The Plan may disclose your PHI when permitted for purposes of public health actions, including when necessary to report child abuse or neglect or domestic violence, to report reactions to drugs or problems with products or devices, and to notify individuals about a product recall. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

Health Oversight. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. Oversight activities can include civil, administrative or criminal actions, audits and inspections, licensure or disciplinary actions (for example, to investigate complaints against providers); other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud); compliance with civil rights laws and the health care system in general.

Lawsuits. Judicial and Administrative Proceedings. If you are involved in a lawsuit or similar proceeding, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process by another individual involved in the dispute, provided certain conditions are met. One of these conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

Law Enforcement. The Plan may disclose your PHI when required for law enforcement purposes, including for the purposes of identifying or locating a suspect, fugitive, material witness or missing person.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose your PHI when required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

Workers' Compensation. The Plan may release your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

National Security and Intelligence. The Plan may release PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Military and Veterans. If you are a member of the armed forces, the Plan may disclose your PHI as required by military command authorities. The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donations. If you are an organ donor, the Plan may disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Research. The Plan may disclose your PHI for research when the individual identifiers have been removed or when the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosure to Secretary

The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to Family Members and Personal Representatives

The Plan may disclose your PHI to family members, other relatives and your close personal friends but only to the extent that it is directly relevant to such individual's involvement with a coverage, eligibility or payment matter relating to your care, unless you have requested and the Plan has agreed not to disclose your PHI to such individual. The Plan will disclose your PHI to an individual authorized by you, or to an individual designated as your personal representative, provided the Plan has received the appropriate authorization and/or supporting documents. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

However, the Plan will not disclose information to an individual, including your personal representative, if it has a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse or neglect by such person or treating such person as your personal representative could endanger you; and
- In the exercise of professional judgment, it is not in your best interest to disclose the PHI. This also applies to personal representatives of minors.

Authorization

Any uses or disclosures of your PHI not described above will be made only with your written authorization. Most disclosures involving psychotherapy notes will require your written authorization. In addition, the Plan generally cannot use your PHI for marketing purposes or engage in the sale of your PHI without your written authorization. You may revoke your written authorization at any time, so long as the revocation is in writing. Once the Plan receives your authorization, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2. RIGHTS OF INDIVIDUALS

You have the following rights with respect to your PHI:

Right to Request Restrictions on PHI Uses and Disclosures. You may request in writing that the Plan restrict or limit its uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to limit disclosures to family

members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. For example, you could request that the Plan not use or disclose specific information about a specific medical procedure you had. However, the Plan is not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. The Plan will not ask you the reason for your request, which must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests to receive communications of PHI by alternative means if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

Right to Inspect and Copy PHI. You have a right of access to inspect and obtain a copy of your PHI (including electronic PHI) contained in the Plan's "designated record set," for as long as the PHI is maintained by the Plan in a designated record set. If you request a copy of the information, the Plan may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

"Designated Record Set" includes the medical records and billing records about an individual maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about the individual. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

If your request is granted, the requested information will be provided to you within 30 days after the receipt of your request in the form and format requested, if it is readily producible in such form and format, or if not, in a readable hard copy form (or a readable electronic form and format in the case of PHI maintained in designated records sets electronically) or such other form and format as agreed upon by you and the Plan. If the Plan is unable to comply with request within the 30-day deadline, a one-time 30- day extension is permissible. In such case, you will receive notification of the need for an extension within the initial 30-day period.

Please note that your right does not apply to psychotherapy notes or information compiled in reasonable anticipation of a legal proceeding. The Plan may deny your request to inspect and copy your PHI in very limited circumstances. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. If you believe that the PHI the Plan has about you is incorrect or incomplete, you have the right to request in writing that the Plan amend your PHI or a record contained in a designated record set for as long as the PHI is maintained by the Plan in the designated record set. The Plan has 60 days after the request is made to act on the request. However, a single 30-day extension is allowed if the Plan is unable to comply with the deadline.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask for the amendment of information that: (1) is not part of the medical information kept by or for the Plan; (2) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information that you would be permitted to inspect or copy; or (4) is already accurate and complete. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.

The Right to Receive an Accounting of PHI Disclosures. You have the right to receive a list of disclosures of your PHI that have been made by the Plan on or after April 14, 2003 (or January 1, 2011 in the case of disclosures of your PHI from electronic health records maintained by the Plan, if any) over a period of up to six years (three years in the case of disclosures from an electronic health record) prior to the date of your request. Certain disclosures are not required to be included in such accounting of disclosures, including but not limited to disclosures made by the Plan (1) for treatment, payment or health care operations (unless the disclosure is made from an electronic health record), or (2) in accordance with your authorization. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice upon Request. You have the right to receive a paper copy of this Notice even if you have agreed to receive this Notice electronically.

To exercise any of your HIPAA rights described above, you or your personal representative must contact the HIPAA Privacy Officer in writing at PO Box 1330, Columbus MT 59019 or by calling (406) 322-8930. You or your personal representative may be required to complete a form required by the Plan in connection with your specific request.

Section 3. THE PLAN'S DUTIES

Notice of Privacy Practices. The Plan is required by law to provide individuals covered under the Plan with notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. In the event of any material change to this Notice, a revised version of this Notice will be distributed to all individuals covered under the Plan within 60 days of the effective date of such change by first-class U.S. mail or with other Plan communications.

Breach Notification. The Plan has a legal duty to notify you following the discovery of a breach involving your unsecured PHI.

Minimum Necessary Standard. When using or disclosing PHI, the Plan will use and/or disclose only the minimum amount of PHI necessary to accomplish the intended purposes of the use or disclosure.

However, the minimum necessary standard will not apply in the following situations:

- Disclosure to or requests by a health care provider for treatment;
- Uses or disclosures made to you; and
- Uses or disclosures that are required by law.

Section 4. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Plan, contact the HIPAA Privacy Officer in writing at PO Box 1330, Columbus MT 59019 or by calling (406) 322-8930.

You will not be penalized or in any other way retaliated against for filing a complaint with the Office for Civil Rights or with the Plan.

Section 5. ADDITIONAL INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the HIPAA Privacy Officer in writing at PO Box 1330, Columbus MT 59019 or by calling (406) 322-8930.