ENERGY TRANSFER

GROWING TOWARD A GREAT FUTURE

2026 BENEFITS GUIDE

NOTICE REGARDING THIS COMMUNICATION

This Guide provides only an overview of benefits changes and clarifications effective January 1, 2026. The respective plan documents govern your rights. You should rely on this information only as a general summary of some of the features of the plans. In the event of any difference between the information contained herein and the plan documents, the plan documents will supersede and control over this Guide. For specific plan details, including eligibility requirements, enrollment rules, benefits, and other program details, please refer to the **Summary Plan Description** and the **Benefit Booklet**. The Partnership expressly reserves the right at any time and for any reason to amend, modify, or terminate one or more of the plans or policies described in this Guide.

GROWING TOWARD A GREAT FUTURE

The Partnership is continually moving and changing. Together, we are headed toward a future filled with possibilities.

The Partnership values all of our employees who make our growth and success possible. We are proud to offer a competitive and affordable benefits package.

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Energy Transfer Benefit Advocate Center
1-855-562-5847
Monday-Friday
7:00 a.m.-6:00 p.m. CT

bac.etbenefits@ajg.com

STARTING POINTS

BENEFITS ELIGIBILITY

You are required to work an average number of hours each week to qualify for benefits.

Let's see how many hours you need to qualify for benefits:

BENEFITS PLAN	HOURS REQUIRED
Medical, dental, and vision	At least 30 hours per week
All other benefits	At least 35 hours per week

COVERING YOUR DEPENDENTS

For the purposes of benefits, eligible dependents are defined as:

- Your **legally married spouse**, including common law spouses. You will be required to submit a Declaration of Marriage issued by the state of residence or, where not available, the Partnership's Affidavit of Common Law Marriage with supporting documentation requested.
- **Your child(ren)** up to age 26
  - Biological children
  - Adopted children
  - Stepchildren
  - Children for whom you have a Qualified Medical Child Support Order (QMCSO)
  - Children for whom you have proven legal guardianship as approved by a court order
- **Disabled children** of any age, if they are disabled prior to age 26, and not eligible for Medicare.

When you enroll your eligible dependent(s), you will be required to provide their legal name(s), Social Security number(s), and date(s) of birth.

BENEFITS CHANGES

There are times when you will need to make a change to your benefits in the middle of the year. To make a change to your benefits outside of the Open Enrollment period, it must be a qualified change in status.

A qualified change in status includes life events that impact eligibility for you or your dependent(s), such as:

- Marriage
- Divorce, legal separation, or annulment
- Birth, adoption, or court-ordered placement of a child
- Court-ordered removal of a child
- Death of your spouse or dependent(s)
- Change in employment status for you, your spouse, or your dependent(s)
- Loss of eligibility for dependent(s) when a child turns age 26
- Change in Medicare status for you or your dependent(s)
- Spouse or dependent(s) becomes covered by other group health coverage
- You gain other group coverage during the plan year
- You or your dependent(s) lose other health coverage during the plan year

WHAT TO DO WHEN YOU HAVE A QUALIFIED EVENT

If you have a qualified event due to marriage, divorce, birth, or adoption of a child, log on to myHR to easily make benefits updates. In myHR, click on My Benefits, select Life Events and follow the steps. You will be able to upload the appropriate documentation (such as a marriage or birth certificate). You must make the change within 31 days of the date of the qualifying event (including the date of the event). Any changes requested after 31 days of the event will not be processed. If you have questions or need help, contact the Energy Transfer Benefit Advocate Center at **1-855-562-5847** or email bac.etbenefits@ajg.com.

MEDICAL

For medical coverage, you have a choice of two options:

- Consumer-Directed Health Plan (CDHP)
- PPO plan

The medical plans offer you and your **eligible dependents** comprehensive coverage for preventive care services, doctor visits, urgent care, and emergency services. Both plans use the same nationwide network of doctors and providers managed by Blue Cross Blue Shield (BCBS).

Here is a quick reference medical dictionary to help guide you through the benefits maze:

TERM	DEFINITION
Coinsurance	The percentage of eligible expenses you and the plan share. The exact coinsurance level depends on whether your providers are in-network or out-of-network.
Copay (or Copayment)	The fixed, up-front dollar amount you pay for certain covered expenses. Copays do not apply toward your deductible or coinsurance, but they do accumulate toward the out-of-pocket maximum.
Deductible	Initial amount you must pay each plan year for covered services before the plan begins to provide benefits (this does not include copays).
Out-of-Pocket Maximum	The amount you pay out of your pocket for eligible health care expenses before the plan pays at 100% for any additional expenses. This is the maximum amount you will have to pay for your care in a given plan year. It includes deductibles, coinsurance, and copays.

For specific plan details, including benefits and other program details, please refer to the **Benefit Booklet**.

Collective Health is your one-stop medical plan claims administrator. To find an in-network doctor, track claims, review eligibility, and download replacement ID cards, visit **my.collectivehealth.com**. You can also download the convenient mobile app for your on-the-go medical information.

PRIOR AUTHORIZATION REVIEW

Some services require authorization prior to services being rendered. If you do not receive prior authorization, your treatment may not be covered. Beginning January 1, your doctor should submit prior authorization requests to BCBS. Watch the **prior authorization video** for more details on how the prior authorization review works.

LANTERN

Coverage for bariatric surgical procedures will be covered only through Lantern. If you do not use Lantern, your surgery will not be covered. **Click here** to learn more.

THE COLLECTIVE HEALTH – BCBS – CVS CONNECTION

Collective Health®

How these groups work together to give you the best medical coverage:

COLLECTIVE HEALTH

Collective Health and Blue Cross Blue Shield of Texas (BCBSTX) partner to bring you a better health care experience. They make it easy to understand, navigate, and access health benefits for you and your family. Collective Health is your main point of contact for finding an in-network doctor, tracking claims, reviewing eligibility, and downloading replacement ID cards.

Collective Health partners with BCBS to use its network of doctors and facilities, allowing you to access some of the best providers nationwide at a lower negotiated cost.

As part of your medical benefits, CVS Caremark provides your pharmacy coverage

Medical Network

BCBS negotiates with doctors, hospitals, and other facilities in its network to get the best value for services. To search for in-network providers or facilities, go to my.collectivehealth.com.

Pharmacy Coverage

Your medical plan includes prescription drug coverage through CVS Caremark. Your pharmacy coverage will be included on your medical ID card. For questions about specific pharmacy coverage, call CVS at 1-800-837-4092.

THE COLLECTIVE HEALTH – BCBS – CVS CONNECTION (CONTINUED)

IMPORTANT TIPS

- Confirm that your provider has a copy of your ID card issued by Collective Health.
- When you receive a bill from a provider, it is important that you have an Explanation of Benefits (EOB) from Collective Health that matches the date of service and charges. If you do not, call your provider to ensure that they have filed your claim.
- Review your EOB carefully and make sure you pay anything that is due to the provider directly to the provider. If you have any questions about how your claim was processed, please call Collective Health's Customer Care Center at 1-855-399-5599.

Let's take a look at a side-by-side comparison of the In-Network CDHP and PPO plans:

PLAN FEATURE	CDHP*	PPO*
Partnership HSA Contribution		
Employee Only	$1,000	None
Employee + Spouse	$1,500	
Employee + Child(ren)	$2,000	
Employee + Family	$2,000	
Preventive Care Services	Plan pays 100%, no deductible or copay	
Deductible		
Individual	$3,750	$1,250
All Other Coverage Levels	$7,500	$3,000
Out-of-Pocket Maximum		
Individual	$4,500	$4,000
All Other Coverage Levels	$9,000	$8,000
Office Visits		
Primary Care Physician (PCP) Doctor Office Visit	Plan pays 90%, after deductible	You pay $25 copay**
Specialist	Plan pays 90%, after deductible	You pay $40 copay**
Labs and X-rays	Plan pays 90%, after deductible	Plan pays 80%, after deductible
Inpatient Hospital Services	Plan pays 90%, after deductible	Plan pays 80%, after deductible
Outpatient Facility	Plan pays 90%, after deductible	Plan pays 80%, after deductible
Emergency Care		
Emergency Room	$200 copay, then plan pays 90%, after deductible	$200 copay, then plan pays 80%, after deductible
Urgent Care	Plan pays 90%, after deductible	You pay $50 copay**

Continued on next page.

PLAN FEATURE	CDHP*	PPO*
Mental Health and Substance Abuse Services		
Office Visits	Plan pays 90%, after deductible	You pay $25 copay**
Inpatient	Plan pays 90%, after deductible	Plan pays 80%, after deductible
Outpatient Facility	Plan pays 90%, after deductible	Plan pays 80%, after deductible
Physical Therapy (over 18 visits per year requires precertification)	Plan pays 90%, after deductible	Plan pays 80%, after deductible
Chiropractic Services (up to 26 visits per year)	Plan pays 90%, after deductible	You pay $40 copay**

* *All coverage amounts assume you use in-network providers for your care.*

** *Copays do not count toward the deductible, but they do count toward the out-of-pocket maximum.*

Medical ID Cards – Additional or replacement cards can be ordered at **my.collectivehealth.com** or accessed digitally in the **Collective Health app**.

MEDICAL MATCHUP

Click here to see how the plans compare in real-life situations.

HOW THE CDHP WORKS

Choosing the medical plan that fits your and your family's needs is an important decision. We want to help you make the right choice.

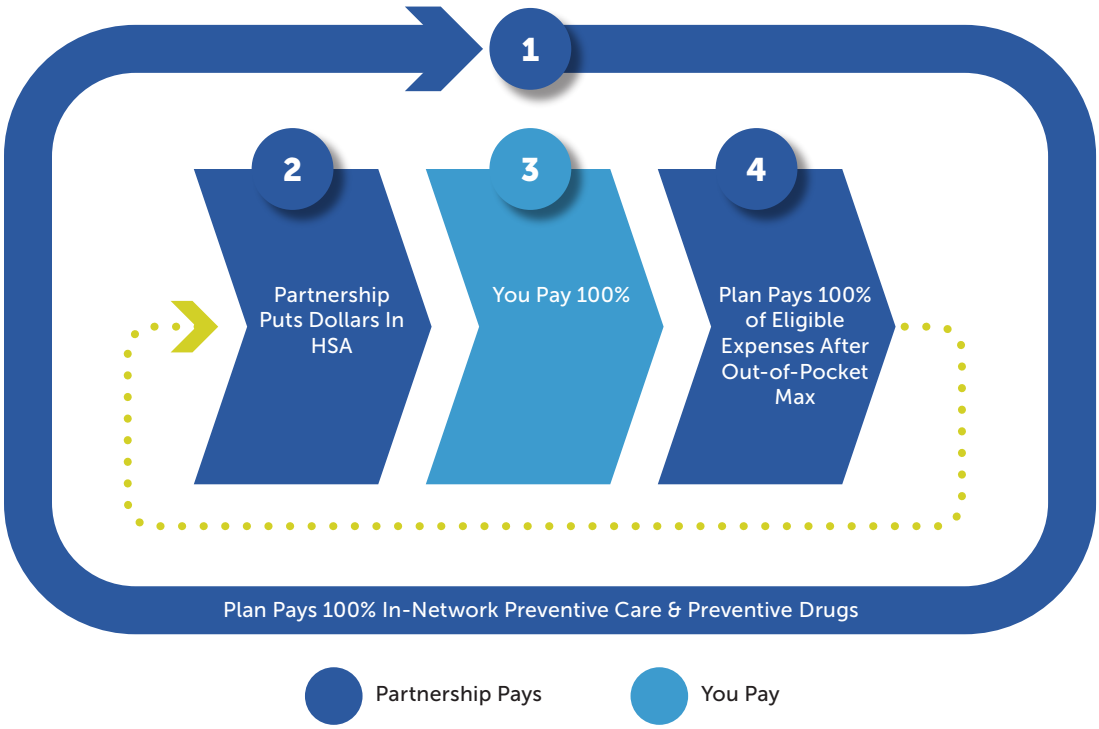
If you choose the CDHP plan, this is how you will pay for care:

1. **The CDHP provides free preventive care.**
When you get in-network preventive care during the year, like annual wellness exams, kids' checkups, and most immunizations, or buy certain qualified preventive drugs, such as prenatal vitamins or smoking cessation drugs, the plan will pay 100% of the cost regardless of whether you have met the deductible.

2. **Your HSA will help pay your deductible.**
If you enroll in the CDHP, the Partnership will set aside dollars in your Health Savings Account (HSA) to help you with medical care during the year, like doctor visits and prescriptions. It's possible that the money in your HSA may be enough to cover all of your costs for the year. You can also contribute your own pre-tax dollars to your HSA and save on your taxes. Learn more in the HSA Details section.

3. **You pay the discounted medical or prescription rates until you meet the deductible.**
If you need to go to a primary care doctor, a specialist, an urgent care clinic, or even an ER that's in the BCBS network, you will pay the BCBS discounted rate for the visit. For example, if your specialist has negotiated with BCBS a rate of $90 for an office visit, you will pay $90 to go to the doctor. You will continue to pay for your care until you reach the annual deductible.

4. **After you meet the deductible, the plan begins to pay.**
If you need a lot of care and meet your deductible during the plan year, the plan will pay 90% of the cost for your care until you reach the out-of-pocket maximum. Then, the plan will pay for all of the cost of your care for the rest of the plan year.



CDHP VS. PPO

Two Plans – Sizing Up the Competition

Now that you know how the CDHP works, it's important to know that both the CDHP and PPO plans cover the same services, use the same network of BCBS providers and pay for 100% of your preventive care (annual wellness exams, kids' checkups, most immunizations, some qualified preventive drugs, and more).

WANT TO LEARN MORE?

Check out our Medical Matchup.

But there are some key differences. Let's take a look at a side-by-side comparison of the plans and see how the differences add up.

	CDHP	PPO
Paycheck Costs	★ **Lower paycheck costs** You pay $261 less each month for non-tobacco Employee + Family coverage. That's a savings of over $3,000 a year!	**Higher paycheck costs** You pay $261 more each month for non-tobacco Employee + Family coverage.
Deductible	**Higher deductible** $3,750 Individual $7,500 All other coverage levels	★ **Lower deductible** $1,250 Individual $3,000 All other coverage levels
Copays and Coinsurance	**No copays, pay less coinsurance** You pay less after the annual deductible is met; plan pays 90% of the cost until the out-of-pocket is met.	**Some copays, pay more coinsurance** You pay copayments for primary care and specialist visits and for other services. Plan pays 80% of the cost until the out-of-pocket is met.
Out-of-Pocket Maximum (includes the Deductible)	★ **Out-of-Pocket maximum includes the deductible but may take longer to reach** $4,500 Individual $9,000 All other coverage levels	★ **Out-of-Pocket maximum is lower** $4,000 Individual $8,000 All other coverage levels
Health Savings Account (HSA)	★ **Yes**	**No**
Partnership Contributions to HSA	★ **Employee Only: $1,000** **Employee + Spouse: $1,500** **Employee + Children: $2,000** **Employee + Family: $2,000** The total annual contribution will be prorated based on eligibility date.	**No up-front dollars** to help with your medical care.
Your Contributions	★ **You can add tax-free dollars** to your HSA each pay period. The most you can contribute for 2026 is: $4,400 Individual $8,750 All other coverage levels The maximum amounts include Partnership contributions.	Not applicable
Prescriptions	★ **Preventive prescriptions covered 100%** Deductible does not apply	**Copays apply to all prescriptions after the pharmacy deductible, excluding generics.**

All coverage amounts assume you use network providers for your care.

WELLNESS EXAMS: WHAT YOU NEED TO KNOW!

Q: WHAT IS A ROUTINE WELLNESS EXAM?

Expect the basics. A routine wellness exam is a comprehensive exam with your primary care provider for the sole purpose of preventive care. An annual wellness exam does not include discussion of new problems or a detailed review of chronic conditions. Annual wellness exams typically take only 45 minutes and include:

- Discussion of past medical, social, and family history
- A complete physical exam (vital signs, blood pressure, heart rate, etc.)
- Any needed preventive immunizations
- Counseling, anticipatory guidance, and/or risk factor reduction interventions
- Review of age/gender appropriate screening lab work

Q: WHAT IS THE PURPOSE OF A ROUTINE WELLNESS EXAM (ANNUAL PHYSICAL)?

Find problems before they start. The purpose of a routine wellness exam is to identify potential health problems in the early stages when they may be easier and less costly to treat. They also can help find problems early, when your chances for treatment and cure are better. This is considered a preventive service and is covered at 100% (at no out-of-pocket cost to you).

Q: WHAT IS THE DIFFERENCE BETWEEN A WELLNESS VISIT AND A DIAGNOSTIC VISIT?

Know the difference and avoid surprise billing. Should your wellness exam turn into a diagnostic or problem-oriented visit, your provider has the right to bill accordingly. Avoid doing a wellness exam and a diagnostic visit on the same day. Preventive visits and tests ordered by your provider help you stay healthy and catch problems early. Diagnostic visits and testing are used to diagnose a current health problem. Diagnostic tests are ordered by your provider when you have symptoms and they want to find out why. For example, your provider might want you to have a test because of your age/family history; that's preventive care. If it's because you're having symptoms of a problem, that's diagnostic care. Schedule a separate appointment on a different day if you have any new concerns or other ongoing health problems that need more attention.

WELLNESS EXAMS: WHAT YOU NEED TO KNOW! (CONTINUED)

Q: WHAT CAN I DO TO MAKE SURE I RECEIVE MY ROUTINE WELLNESS EXAM BENEFIT?

Do your research and be prepared. Take the following steps to help ensure your routine wellness exam is billed correctly:

1. Use the terms "routine wellness exam" or "annual physical," not "checkup," when scheduling an appointment.
2. When you talk with your provider, let them know you are there for your routine wellness exam.
3. You may ask questions about how existing conditions (e.g., a skin rash) relate to your current health, but if you pursue treatment during your routine preventive exam, understand your provider may bill additional non-routine services. These services would not be part of your routine wellness exam and would be processed at the applicable benefit level.
4. Do not save up all of your health concerns for your routine wellness exam.

Q: WHAT DO I DO IF I FEEL AN ERROR HAS BEEN MADE ON MY BILL?

Call Customer Care. A dedicated Customer Care number is listed on the back of your member ID card so you can talk with a Customer Service Representative. You can also contact your provider's office to ask questions and to see if a coding review is warranted.

Call: 1-855-399-5599
or
Visit: my.collectivehealth.com

HSA DETAILS

If you choose the CDHP plan, the Partnership sets aside money in a separate bank account under your name. If you are benefits-eligible as of January 1, half of the Partnership dollars will be deposited into your HSA in January, and the remaining half will be deposited into your HSA account in July.* If you are benefits-eligible on February 1 or later, your contribution will be prorated based on your eligibility date, and a portion ($38.46, $57.69, or $76.92) will be deposited into your account each pay period. You will receive a Visa debit card to access your account to pay for medical expenses. You can easily manage your HSA online at participant.pncbenefitplus.com/login.

You Can Contribute Too

Contributing to your HSA will also reduce your taxable income. When you make contributions to your HSA, the dollars come out of your paycheck before taxes, which lowers your taxable income. You can also deposit funds directly to your HSA, then deduct the contribution from your taxable income at year-end. Your account earns interest tax-free, and investment earnings on balances, if any, are also tax-free. Given the tax-free benefits of an HSA, the IRS sets a limit on how much can be deposited into your account each year. You can see how the IRS limit works below:

	2026 IRS LIMIT	2026 PARTNERSHIP* CONTRIBUTION	LIMIT FOR YOUR CONTRIBUTIONS
Employee Only	$4,400	$1,000	$3,400
Employee + Spouse	$8,750	$1,500	$7,250
Employee + Child(ren)	$8,750	$2,000	$6,750
Employee + Family	$8,750	$2,000	$6,750

If you are age 55 or over, IRS rules allow you to make additional catch-up contributions to HSAs in the amount of $1,000.

* *Partnership contributions, one half in January and one half in July, are based on CDHP coverage level as of January 1. If you have a qualifying life event and adjust your CDHP coverage, there will be no adjustment to the Partnership HSA contribution. You must be employed with the Partnership at the time the HSA deposit is made.*

IRS HSA RULES

If you have filed an application or participate in Medicare Part A or Parts A and B, you are not eligible to contribute to a Health Savings Account (HSA). Also, if you are enrolled in another plan that offers an HSA or Flexible Spending Account (FSA) (i.e., through a spouse's plan), you are not allowed to contribute to a second HSA. For more information, visit the FAQs.

DOCTOR ON DEMAND BY INCLUDED HEALTH

Out of town or unable to make it to your primary care doctor? Try telehealth through Doctor on Demand by Included Health. It's a great alternative to costly ER or urgent care visits.

You will have round-the-clock access to board-certified doctors and licensed therapists through video visits online or through the mobile app. You can receive assistance with non-emergency medical and behavioral health issues, such as allergies, colds, bronchitis, stress, depression, and more. Doctor on Demand can even write orders for lab tests and prescriptions that will be sent directly to your local pharmacy.

The cost per visit varies based on the services needed. The best part is if you hit your out-of-pocket maximum in your medical plan, there is no additional charge to use Doctor on Demand.

COST PER VISIT	
Service	**Cost**
Medical	$25 PPO / $60 CDHP
Psychology	$85-$139
Psychiatry	$107-$247

REGISTRATION

Register today and be prepared for an unexpected illness. Go to **doctorondemand.com**, select Collective Health, and enter the Member ID and Group ID from your insurance card to complete your registration. Be sure to download the convenient Doctor on Demand mobile app for on-the-go care.

LANTERN

1

NEED SURGERY? ENERGY TRANSFER HAS A WAY TO HELP YOU PLAN AND PAY LESS.

Medical care is expensive. Even with health coverage, surgery often costs thousands of dollars. The Partnership wants you to get the care you need without taking a tough financial hit.

2

IT'S LANTERN.

Surgery is complicated. But with Lantern, finding a top-quality surgeon and facility is simple. The Partnership also picks up the entire cost after you meet your deductible.

3

YOUR CONCIERGE FOR SURGERY CARE

When you need surgery, Lantern makes the process simple. With one call, Lantern will coordinate every detail—from scheduling to paperwork—so you can focus on your health, not logistics.

Extra HSA Incentive for CDHP Members
If you're enrolled in the CDHP plan, you'll also receive an additional contribution to your HSA:

- $250 for minor surgery
- $1,000 for major surgery (up to $1,000 per family each year)

That means less stress, more support, and added savings for your care.

4

HOW DOES IT WORK?

As soon as your doctor mentions that you may need surgery, call Lantern to connect with a dedicated Care Advocate who will locate the best-fitting providers, schedule all appointments, coordinate medical records, and book travel if necessary. Your Care Advocate will also assist you post-procedure with scheduling follow-up appointments. They will even help make sure your medical records are sent to your primary care doctor. Your health and satisfaction is their top priority.

Visit lanterncare.com or call 1-855-200-9512 to learn more.

LANTERN

BARIATRIC SURGERY COVERAGE

Beginning January 1, 2026, bariatric surgeries must be scheduled through the Lantern program to be covered. These are highly complex procedures, and the Partnership wants to ensure you have exclusive access to top-quality surgeons and support.

If you choose to have a bariatric procedure without utilizing the Lantern benefit, it will not be covered by the plan.

In addition to bariatric surgeries, Lantern offers concierge support for a wide range of surgical procedures—helping you find top-rated providers, coordinate care, and simplify the process with just one call.

PROGYNY

We understand the road to parenthood can be challenging and believe that everyone should have access to the care they need to have the family they deserve. That's why we have partnered with Progyny.

Your benefit includes comprehensive treatment coverage leveraging the latest technologies and treatments, access to high-quality care through a premier network of fertility specialists, and personalized emotional support and guidance from dedicated Patient Care Advocates.

SMART CYCLES

To make your fertility benefit easier to understand and use, Progyny has bundled the individual services, tests, and treatments you may need into Progyny Smart Cycles.

COVERAGE

The Progyny coverage is a carve-out of the medical plan, with its own deductible and out-of-pocket maximum that are separate from the medical plan deductible and out-of-pocket maximum. The Progyny plan features include:

FEATURE	AMOUNT
Deductible	$4,000
Out-of-Pocket Maximum	$8,000
Coinsurance	Pays 80%, after deductible

GET STARTED

To learn more about fertility options and get additional education, **click here**. When you're ready to get started, call to speak to a Patient Care Advocate at 1-833-278-1139.

ADOPTION PROGRAM

The Partnership offers an adoption program through Progyny. Once the adoption is finalized, the program will pay a lump-sum reimbursement payment, up to $10,000, for eligible expenses, including:

- Adoption fees
- Home studies
- Legal fees and court costs
- Immigration and immunization fees
- Temporary foster care expenses

progyny
Smarter Fertility Benefits

PRESCRIPTION DRUGS

When you choose the CDHP or PPO medical option, you also receive prescription drug coverage through CVS Caremark.You will receive a consolidated ID card with medical and pharmacy information. Additional ID cards can be ordered at my.collectivehealth.com. ID cards are also available on the Collective Health app.

The amount you pay for prescriptions is different with each medical plan. Let's take a look at the prescription drug coverage:

PLAN FEATURE	CDHP*	PPO*
Retail prescriptions (30-day supply)		
Generic	The plan pays 100% for preventive drugs. For all other drugs, the plan pays 90% after deductible.	$7 copay
Preferred brand		$40 copay, after deductible
Non-preferred brand		$70 copay, after deductible
Mail order prescriptions (90-day supply)		
Generic	The plan pays 100% for preventive drugs. For all other drugs, the plan pays 90% after deductible.	$14 copay
Preferred brand		$80 copay, after deductible
Non-preferred brand		$140 copay, after deductible
Specialty drugs		
Specialty	The plan pays 100% for preventive drugs. For all other drugs, the plan pays 90% after deductible.	$100 copay, after deductible

All coverage amounts assume prescriptions are filled through a CVS Caremark network provider. Employees in Florida and Oklahoma may use the pharmacy of their choice outside of the CVS Caremark network, per applicable state law.

Unsure of the type of prescription you are taking? Log in to your individual account at caremark.com to view the most up-to-date drug list and check the cost of your drug.

PPO PRESCRIPTION DEDUCTIBLE

Prescriptions in the PPO plan will be subject to a $150 per person or $300 family deductible. Copays will apply after the deductible is met. Generic prescriptions will not be subject to the deductible.

PRESCRIPTION DRUG PROGRAMS

MANDATORY GENERIC DRUGS SAVE YOU MORE

If you choose to purchase a brand-name drug (preferred brand, non-preferred brand or specialty) instead of a generic alternative, you will be responsible for the difference in cost between the brand and the generic. The cost difference will not apply to the deductible or out-of-pocket maximum.

PRIOR AUTHORIZATION AND QUANTITY LIMITS

Some newer, more expensive or frequently overused drugs may require your provider to get advance approval. Also, if a prescription quantity exceeds CVS Caremark's criteria, your provider may need to provide documentation. This ensures that a safe and effective dosage of your drug is dispensed, while containing waste or deterring inappropriate use.

STEP THERAPY

Step therapy is all about getting the most effective medication for your health and money. That means using a quality medication that's proven safe and effective for your condition at the lowest possible cost to you and the Partnership.

How does step therapy work?

Step therapy is designed for people who regularly take prescription drugs to treat ongoing medical conditions such as arthritis, asthma, or high blood pressure. Prescription medications are grouped into two categories:

1. **Step 1 medications** are generic drugs that have been rigorously tested and approved by the FDA. Generics should be prescribed first because they can provide the same health benefits as higher-cost medications.

2. **Step 2 medications** are brand-name drugs such as those you see advertised on TV. They are recommended only if a Step 1 medication does not work for you. Step 2 medications almost always cost you and your plan sponsor more than Step 1 medications.

Ask your doctor if a generic (Step 1) medication may be right for you. Please share your preferred brand (the list of prescription drugs covered by your plan)with your doctor. If your doctor prescribes a Step 2 medication, the pharmacy will not automatically change your prescription; your doctor must write a new prescription for you to change from a Step 1 medication to a Step 2 medication. If a Step 1 medication is not a good choice for you, your doctor can request prior authorization to determine if a Step 2 medication will be covered by your plan.

MAINTENANCE CHOICE

Getting a 90-day supply of maintenance prescription drugs is easier than ever. Choose convenient home delivery or pick up at a local CVS pharmacy.* You are in control, with two ways to fill your prescription:

CVS Pharmacy

- Pick up your prescription on your schedule.
- Enjoy same-day pickup.
- Talk with a pharmacist in person.

CVS Caremark Home Delivery Service

- Easy delivery to your home.
- Prescription drugs arrive in private, tamper-resistant, and, when needed, temperature-controlled packaging.
- Automatic refill options help you stay on track.
- Manage your prescriptions and track orders 24/7 at caremark.com.

If you have questions about your prescriptions, the CVS Caremark Customer Care team is available 24 hours, seven days a week. Call 1-800-837-4092.

CVS Specialty Drugs

Specialty drugs must be filled through CVS Specialty. You will still have access to the same convenient services like online ordering, CVS pharmacy in-store pickup or home delivery, and more. For additional information, visit cvsspecialty.com or call 1-800-237-2767 to speak to a CVS Specialty Care Team support member.

* Employees in Florida and Oklahoma may use the pharmacy of their choice outside of the CVS Caremark network, per applicable state law.

QUESTIONS ABOUT HOME DELIVERY?

Review the prescription drug FAQs to learn important tips on filling your prescriptions.

TRIA HEALTH

SAVE MONEY ON YOUR MEDICATIONS

Tria Health provides one-on-one, confidential telephonic counseling with a pharmacist to make sure your medications are working as intended and you can afford them. Tria Health's pharmacists are your personal medication experts and will work with you and your doctor(s) to make sure your conditions are properly controlled without the risk of medication-related problems.

Who should participate?

Tria Health is recommended for members who take multiple medications or have the following conditions:

- Diabetes
- High Cholesterol
- Specialty Conditions
- Mental Health
- Osteoporosis
- Heart Disease
- High Blood Pressure
- Chronic Pain
- Asthma/COPD
- Migraines

Active participants can receive up to $150.

You will receive a $50 Tria Health Visa Rewards Card and/or E-certificate by attending pharmacist consultation(s). You can qualify to receive up to $150 by attending three consultations within a 12-month period.

If you have diabetes, you will have free access to a wireless blood glucose meter, testing strips, and mobile app designed to help better manage your diabetes.

Why participate?

Pharmacists are the experts in how medications work and can provide valuable feedback to you and your doctor(s). Your Tria Health pharmacist can help:

- Make sure your medications are working as intended
- Help save you money
- Answer any questions you have about your health

Ready to get started?

To schedule your first appointment, call 1-888-799-TRIA (8742) or visit www.triahealth.com/enroll.

CHOOSE TO LOSE!

If you are overweight and ready to make the commitment to improving your health, the Choose to Lose program provides the tools and resources you need to achieve long-term weight loss success. You will have access to a designated health coach, clinical pharmacist, and health and fitness app. Visit triahealth.com/CTL-ET to learn more.

NEED HELP KICKING THE HABIT?

The Tria Health Stop Tobacco by Optimizing Pharmacists (S.T.O.P.) Program makes quitting tobacco easy.

Visit Tria Health online or call 1-888-799-TRIA (8742) for more information.

tria HEALTH

DENTAL

The dental plan offers you and your eligible dependents coverage for preventive, basic, and major services. The plan uses a nationwide network of dentists and facilities managed by Delta Dental.

If you enroll in the plan, you will receive two Delta Dental ID cards for you and your covered dependents. You will use your Delta Dental ID card when you visit the dentist.

Let's take a look at the dental plan coverage:

PLAN FEATURES**	COVERAGE AMOUNT*
Deductible, waived for preventive care services	$50 per year, per person
Annual benefit maximum (excludes preventive and orthodontia)	$2,500 per person
Orthodontia lifetime maximum	$1,500 per person
Preventive services (exams, cleanings, x-rays, sealants)	Plan pays 100%, no deductible
Basic services (fillings, simple tooth extractions, root canals, gum treatment, and oral surgery)	Plan pays 80%, after deductible
Major services (crowns, inlays, cast restoration, bridges, dentures)	Plan pays 50%, after deductible
Orthodontia (adult and child)	Plan pays 50%, after deductible

* *All coverage amounts assume you use Delta Dental providers for your care. Reimbursement is based on DPO contracted fees for DPO dentists and Premier contracted fees for Premier dentists.*

** *Limitations may apply for some benefits. Some services may also be excluded from the plan. Reimbursement is based on Delta Dental maximum contract allowances. For information about coverage, cost of care or limitations, contact **Delta Dental**.*

FIND A DENTIST

Visit Delta Dental to see if your dentist is in the Delta Dental network or find a new provider. Remember, you can save money when you use a Delta Dental provider.

VISION

The vision plan is designed to meet your vision needs today and help protect your future eye health. The plan is managed by Vision Service Plan (VSP) and provides coverage for regular eye exams, glasses lenses and frames, and contact lenses for you and your eligible dependents.

If you enroll in the plan, you will not receive a vision ID card. When you go to the eye doctor to receive vision services, your provider will ask for your Social Security number to verify coverage.

Let's take a look at the vision plan coverage:

PLAN FEATURE	COVERAGE AMOUNT*
Eye exam — one every 12 months	You pay $10 copay
Prescription glasses: • Lenses — one set every 12 months • Frames — one set every 24 months for adults (every 12 months for children)	You pay $25 copay, then select lenses and frames** covered in full
Contact lenses — one set every 12 months in lieu of glasses	• Necessary — covered in full, after a $25 copay • Elective — contact lenses and fitting evaluation covered up to $200 every 12 months after $60 copay

** All coverage amounts assume you use a VSP provider for your care.*

*** There are limits on glasses frames. Please see your VSP Summary for details.*

ENHANCEMENTS AND ALLOWANCES	
Retail Frame	$200
Featured Frame Brand	$220
Costco Equivalent Frame	$110
Elective Contact Lenses	$200
Anti-Reflective Coatin	$41 – $85
Polycarbonate Lenses (Adults)	$35
Standard Progressives	Covered in Full
Premium Progressives	$95 – $175

FIND A DOCTOR

Visit VSP to see if your eye doctor is in the Vision Service Plan network or find a new provider. Remember, you can save money when you use a VSP provider.

FLEXIBLE SPENDING ACCOUNTS

The Partnership provides two great ways for you to save pre-tax money to pay for health care and day care — Health Care and Dependent Care Flexible Spending Accounts (FSAs). Both FSAs are administered by WEX Health Inc.

- Health Care FSA: You may contribute up to $2,500 for eligible medical expenses.
- Dependent Care FSA: You may contribute up to $5,000 for eligible dependent day care expenses.
  - Please note that this is not for medical care for your dependents. This account can help you set aside dollars to pay for day care for your kids under the age of 13, or adult dependents who need care during the day.

Remaining Funds. For the 2025 plan year, you may carry over up to $500 of unused Health Care FSA funds to the next plan year. Any funds over the amount of $500 remaining in your account at the end of the year will be forfeited. All claims from 2025 must be filed with WEX Health Inc. by March 31, 2026, to be considered for reimbursement. Visit **WEX Health Inc.** for details on filing your FSA claims.

Please note: If you elected an FSA in 2025 and change to the CDHP with HSA for 2026, you must use your 2025 FSA funds by December 31, 2025. If you do not, you will forfeit any funds remaining in your FSA on December 31, 2025.

PAYING FOR ELIGIBLE EXPENSES

You can pay for eligible expenses in one of two ways:

1. Pay for services and products up front, then submit a claim for reimbursement. You can have your funds automatically deposited into your checking or savings account, or receive a check.
2. Pay eligible expenses with your WEX Health Inc. Debit Card. Payments are automatically withdrawn from your FSA, so you do not have to pay out of pocket when you are purchasing.

See your WEX Health Inc. FSA Guide for details on paying for eligible expenses.

Please note: You can use your WEX Health Inc. debit card as a credit card to avoid the $2.00 debit transaction fee.

WHO IS ELIGIBLE FOR THE HEALTH CARE FSA?

PPO plan participants are eligible for the Health Care FSA. If you enroll in the CDHP with HSA, by law you are **not eligible** to contribute to the Health Care FSA. CDHP with HSA participants may contribute to the Dependent Care FSA only.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT

The Partnership provides a basic level of financial protection for you and your family with Life and Accidental Death and Dismemberment (AD&D) Insurance benefits.

BASIC LIFE AND AD&D

Basic Life Insurance pays a benefit if you or a covered family member dies. Accidental Death & Dismemberment Insurance pays a benefit if you die or suffer a serious injury due to an accident. Basic Life and AD&D Insurance is paid for by the Partnership.

SUPPLEMENTAL LIFE AND AD&D

You can also purchase Supplemental Life and AD&D for yourself, your spouse, and your child(ren.) Supplemental Spouse Life and AD&D coverage cannot exceed the sum of your Employee Basic Life coverage plus your Supplemental Employee Life and AD&D coverage. You must enroll in Supplemental Life for yourself in order to enroll in Supplemental Life for your spouse, and your spouse can not exceed 100% of your coverage amount.

Let's take a look at the Life and AD&D coverage:

	YOU	SPOUSE	CHILD(REN)
Basic Life and AD&D (Partnership pays)	1.5 times your annual base salary, up to a $750,000 limit (Life and AD&D)	$20,000 (Life only)	$10,000 (Life only)
Supplemental Life and AD&D (You pay)	• 1–6 times your annual base salary, up to a $2 million limit • No Evidence of Insurability (EOI) required if you already have coverage and wish to increase your coverage by one salary increment (up to 3X salary or $400,000, whichever is less).	• Coverage in increments of $25,000, up to a $250,000 limit • No EOI required if you already have coverage and wish to increase your coverage by one $25,000 increment. EOI will be required to increase more than one increment, for coverage over $100,000 or to enroll an existing spouse for whom you did not elect coverage when first available.	• Coverage in increments of $5,000, up to a $20,000 limit • No EOI required

Imputed income will be assigned for employer paid life insurance premiums in excess of $50,000 for employee coverage and $2,000 for dependent coverage..

AGE REDUCTION INFORMATION

Basic and Supplemental Life Insurance benefits are reduced from the original amount by 35% at age 65, by 55% at age 70, and by 70% at age 75.

DISABILITY

The Partnership provides disability coverage if you miss work due to an illness or non-work-related injury.

SHORT TERM DISABILITY

The Partnership provides Short Term Disability coverage, at no cost to you, through Sedgwick. Short Term Disability coverage provides you with income replacement after you have met the elimination period (four or five days according to your eligible class) and after you have provided appropriate medical certification for your illness or non-work-related injury. You must have been employed by the Partnership for at least six months and be regularly scheduled to work 35 or more hours a week to be eligible for this benefit.

Let's take a look at the Short Term Disability coverage:

YEARS OF COMPLETED SERVICE	PERCENTAGE OF EMPLOYEE'S PRE-DISABILITY BASE EARNINGS REDUCED BY OTHER INCOME BENEFITS			TOTAL WEEKS OF SHORT-TERM DISABILITY PAY
	100%	80%	60%	
More than 6 months, less than 1 year	0 weeks	2 weeks	2 weeks	4 weeks
1-5 years	3 weeks	8 weeks	15 weeks	26 weeks
6-10 years	6 weeks	12 weeks	8 weeks	26 weeks
11 or more years	12 weeks	10 weeks	4 weeks	26 weeks

* *Payments begin after elimination period. Available PTO must be used to satisfy the elimination period. Employees who qualify to receive a state disability benefit shall have their paid leave benefit payments offset in an amount equal to the payment received from the state.*

LONG TERM DISABILITY

The Partnership also provides Long Term Disability coverage through Sun Life. The benefit replaces 60% of your monthly pay, up to a limit of $10,000 per month, after a 6-month (180-day) eligibility waiting period. The Partnership pays the full cost of this coverage.

WORKERS COMPENSATION

Employees out of work for a compensable job-related injury will be paid according to the STD Schedule of Benefits less any indemnity payment issued by Gallagher Bassett.

CONVENIENT ONLINE CLAIMS

You can submit and manage your claims online or over the phone. To get started, just go to mySedgwick.com/energytransfer or call 1-855-397-0130.

GROUP CRITICAL ILLNESS INSURANCE

Critical illness insurance is available to you and your eligible dependents through Sun Life.

Critical illness coverage offers peace of mind if you are diagnosed with a critical illness, like cancer or heart disease. The coverage provides lump-sum cash benefits, in addition to your medical benefits, to help you cover out-of-pocket expenses for the treatment of your illness. If elected, you will pay the full cost of this additional coverage. The benefit is also portable, so you can take it with you if you leave the Partnership in the future.

Let's take a look at the two critical illness coverage options:

CRITICAL ILLNESS (PER OCCURRENCE)	LOW OPTION*	HIGH OPTION*
Heart Attack	$10,000	$20,000
Stroke	$10,000	$20,000
Coronary Artery Bypass Surgery	$2,500	$5,000
Major Organ Transplant (heart, lung, liver, pancreas or kidney)	$10,000	$20,000
End Stage Renal Failure (peritoneal dialysis or hemodialysis)	$10,000	$20,000
Waiver of Premium (employee only)	Yes	Yes
Cancer Critical Illness Benefits		
Invasive Cancer (includes leukemia and lymphoma)	$10,000	$20,000
Carcinoma in Situ	$2,500	$5,000
Additional Benefits		
Wellness Benefit	$50	$50

* *Covered dependents enrolled in this benefit will receive 50% of the amounts shown for his/her diagnosis.*

EVIDENCE OF INSURABILITY (EOI)

EOI is not required for initial or open enrollment. Visit **Sun Life** for more information.

Critical Illness benefits are supplemental and do not replace your medical plan benefits. Pre-existing limitation may apply.

GROUP CANCER INSURANCE

Group cancer insurance is available to you and your eligible dependents through Sun Life.

Optional cancer insurance offers peace of mind if you are diagnosed with cancer. The plan provides cash you can use to cover financial needs — medical and non-medical — related to dealing with cancer. If elected, you will pay the full cost of this additional coverage. Premiums are waived if you are totally disabled and unable to work for 90 days due to a cancer diagnosis. The benefit is also portable, so you can take it with you if you leave the Partnership in the future.

Let's take a look at the two cancer insurance coverage options:

PLAN FEATURE CANCER CARE/SERVICE/FACILITY	LEVEL 1	LEVEL 2
Continuous hospital confinement	$200/day	$400/day
Extended care facility	$200/day	
Hospice	$100/day	
Radiation, chemotherapy, and related benefits		
Chemotherapy	$300/week	$1,000/week
Blood or plasma	$50/day	
Radiation	$400/week	$500/week
Surgery and related benefits		
Surgery	$150-$5,500	$150-$7,500
Anesthesia	$50-$1,815	
Second opinion	$200	
Inpatient physician's visit (75 limit)	$25/visit	
Inpatient drugs and medication	$25/day	

Visit Sun Life for a complete list of covered services, limitations, and terms and conditions. Pre-existing condition limitations may apply.

GROUP CANCER INSURANCE (CONTINUED)

PLAN FEATURE CANCER CARE/SERVICES/FACILITY	LEVEL 1	LEVEL 2
Cancer screening (1/year)	$50	$75
Skin cancer biopsy	$100	
Skin cancer removal (varies based on procedure)	$375-$600	
Ambulance (2 one-way trips/confinement)	$250	
Outpatient lodging ($2,000 limit/year)	$50/day	
Prosthesis (surgical implant/lifetime)	$2,000	$3,000
Additional Level 2 Benefits		
Cancer initial diagnosis (one-time benefit)	Not available	$5,000
National Cancer Institute consultation (one-time benefit)		$500
Anti-nausea benefit		$100/month
Immunotherapy ($3,500 lifetime max)		$450/month
Bone marrow transplant		$200
Stem cell transplant		$2,500
New or experimental treatment		$150/day
Home health care and alternative care		$50/visit
Reconstructive surgery (varies based on service)		$350-$2,500
Nursing services (30 day limit/year)		$125/day
Airfare (2 one-way trips/confinement)		$2,000
Family member lodging (if 100 miles from residence)		$100/day
Family member transportation (if 100 miles from residence)		$500
Post-hospital doctor visits (1 per 6 months for 5 years)		$50/visit

Visit **Sun Life** for a complete list of covered services, limitations, and terms and conditions. Pre-existing condition limitations may apply.

EVIDENCE OF INSURABILITY (EOI)

EOI is not required for initial or open enrollment. Visit **Sun Life** for more information.

Cancer benefits are supplemental and do not replace your medical plan benefits.

SUPPLEMENTAL BENEFITS

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Managing life can seem overwhelming. The ComPsych EAP Complete program is here to provide help when you need it most. For no additional cost, you, your spouse, dependent children, parents, and parents-in-law have 24/7 access to license professional counselors who can help you with:

- Stress, depression, and anxiety
- Relationship issues
- Anger, grief, and loss
- Job stress
- Family and parenting problems
- Alcohol and drug abuse

You can also access a Guidance Consultant who can help you balance work and life issues by answering your questions and helping you find resources in your community for:

- Child or elder care
- Legal questions
- Wills and trusts
- Time management
- Finance and debit management
- Reducing your medical/dental bills

GETTING CARE IS EASY

You can get unlimited, 24/7 confidential support:

Phone: 1-877-595-5284
Online: guidanceresources.com
App: GuidanceNow℠
Web ID: EAPComplete

You can get up to five in-person visits with a licensed professional counselor as part of the program. Your counselor may refer you to other resources in your community for ongoing support.

HEADSPACE + CARE: MENTAL HEALTH SUPPORT AT NO COST

New for 2026! Employees and their covered dependents now have access to Headspace + Care — a mental health and wellbeing program that combines personal coaching, clinical care, and mindfulness resources.

What's Included:

- **Coaching**: Connect with certified coaches for everyday challenges like stress, anxiety, relationships, or work pressures. Available quickly via private, text-based chats.
- **Clinical Care**: For more support, meet virtually with licensed clinicians. Appointments are available within days, including evenings and weekends. Coaches and clinicians work together to ensure you get the right level of care.
- **Mindfulness & Meditation**: Explore hundreds of guided exercises designed to help you manage stress, sleep better, build resilience, and create healthy habits.

Coverage:

- Up to 8 counseling sessions at no cost for employees and their covered dependents.
- Access to the Headspace app with full features.

GET STARTED:

Visit Headspace.com to register and begin using Headspace + Care.

SUPPLEMENTAL BENEFITS (CONTINUED)

TRAVEL ASSISTANCE

Even the most well-planned travel can have unexpected problems. When trouble strikes, Assist America is here to help. When you are traveling 100 miles or more away from home, Assist America can help you with emergency medical assistance and evacuation, short-term prescription replacement, personal services, passport replacement, and more. Assist America can even help with pre-trip information and country guidelines.

When you are far away from home, Assist America is just a call away at **1-800-872-1414**.
Reference No: 01-AA-SUL-100101

IDENTITY THEFT PROTECTION

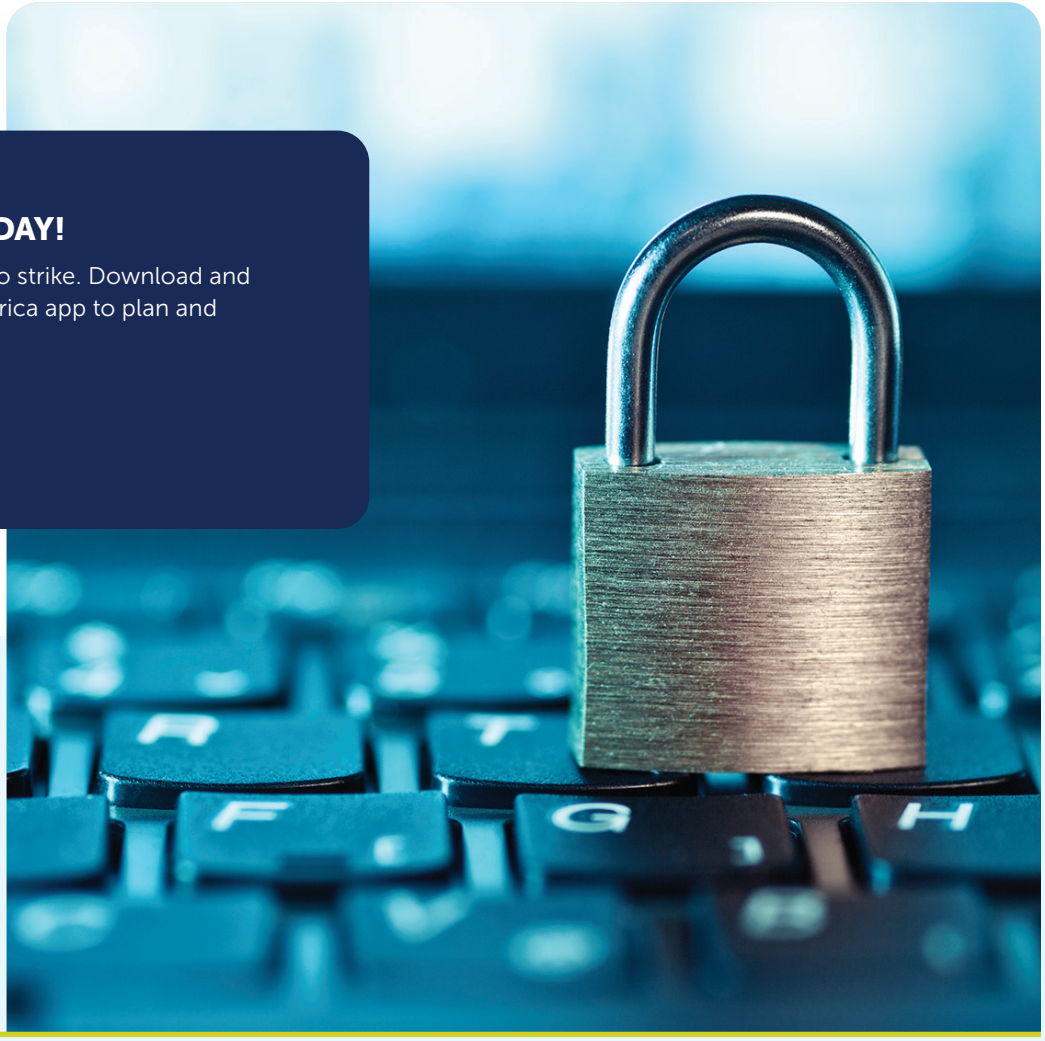
In today's digital age, protecting your personal information is critical. Cyberattacks can happen at any time, but with a simple two-step process, you can safeguard your name and credit history.

DOWNLOAD TODAY!

Don't wait for trouble to strike. Download and activate the Assist America app to plan and prepare for your trip.

Apple App Store

Google Play Store



HOLIDAYS

We all need to recharge every now and then—so the Partnership provides you with 10 holidays plus one additional floating holiday for a total of 11 holidays. If a holiday falls on a weekend, the day of observance may vary.

Below are the Partnership holidays:

HOLIDAY	DAY OBSERVED
New Year's Day	Thursday, January 1
Good Friday	Friday, April 3
Memorial Day	Monday, May 25
Independence Day	Friday, July 3
Labor Day	Monday, September 7
Thanksgiving	Thursday, November 26
Day After Thanksgiving	Friday, November 27
Christmas Eve	Thursday, December 24
Christmas Day	Friday, December 25
New Year's Eve	Thursday, December 31
Floating Day	You choose the day, subject to manager approval

EDUCATION BENEFIT

The Partnership wants to support your education by providing education benefits. Employees who work an average of 35 hours or more per week are eligible for up to $5,250 in tuition reimbursement per year. For more information, please click on the Educational Assistance Plan tile under Human Resources on the Partnership's intranet site.

COMMUTER BENEFIT

For employees living in New Jersey, the Partnership offers employees the option to set aside pre-tax dollars, up to $340 per month, for commuter expenses, which includes van-pooling and transit passes. Visit **WEX Health Inc.** for additional details.

PAID TIME OFF (PTO)

The PTO program provides you greater flexibility and control in managing your time away from work. The PTO program will allow up to 40 hours of accrued but unused PTO to carry over to the following year. 12-hour shift workers can carry over up to 48 hours of accrued unused PTO to the following year. You must work 35 or more hours per week to be eligible for benefits.

	PAID TIME OFF (PTO)								
	8-HOUR EMPLOYEE			10-HOUR EMPLOYEE			12-HOUR EMPLOYEE		
YEARS OF SERVICE	DAYS	HOURS	MONTHLY ACCRUAL	DAYS	HOURS	MONTHLY ACCRUAL	DAYS	HOURS	MONTHLY ACCRUAL
0-2 years*	16	128	10.67	12	120	10	11	132	11
3-4 years	17	136	11.33	13	130	10.83	12	144	12
5-9 years	22	176	14.67	17	170	14.17	15.5	186	15.5
10-19 years	27	216	18	21	210	17.5	19	228	19
20-29 year	32	256	21.33	25	250	20.83	22.5	270	22.5
30+ years	35	280	23.33	29	290	24.17	25	300	25

* *For those employed less than one year, time will be prorated based on the hire date.*

PAID MATERNITY LEAVE

The Partnership will provide employees up to eight consecutive weeks for normal birth and ten consecutive weeks for cesarean birth of paid maternity leave at 100% of base wages following the birth of a child. If a holiday coincides with the leave, the holiday will not extend the duration of the leave. To request paid maternity leave, you will need to file a claim with Sedgwick and submit the required documentation.

Paid leave is subject to normal taxes and payroll deductions. Leave requests should be submitted four weeks in advance or as soon as practical. Paid leave will run concurrently with Family Medical Leave.

YOUR FUTURE

401(K) PLAN

To help plan for your future, the Partnership sponsors a 401(k) plan administered by Principal Financial Group. The 401(k) plan is a great way to plan for your future; you control how much you save and how you invest your funds.

Eligibility

If you are an employee, you are eligible to join on your first day of employment. Contractors, students, and interns are not eligible to participate.

Your Contributions

Newly hired employees will be automatically enrolled at a 5% salary deferral rate. You can change your deferral percentage at any time by contacting Principal. You may contribute 1% to 75% of your eligible base pay up to the IRS limits. You can make contributions pre-tax to a traditional account or after-tax to a Roth IRA.

IRS CONTRIBUTION LIMITS	
Salary Deferral	Catch-up Contributions*
$24,500	$8,000

* *Must be age 50 or over*

Employer Match Contributions

The Partnership will match 100% of the first 5% of all eligible base wage contributions. Catch-up contributions are not matched.

Profit-Sharing Contributions

Employees below the Director level and earning $200,000 or less annual base pay will receive a discretionary contribution of 3% of eligible base pay. Contributions are made on a pay period basis. The Partnership will review profit-sharing contributions annually to determine if a payment will be made. The amount contributed, if any, may change yearly.

Vesting

Employer match and profit-sharing contributions have a five-year vesting schedule.

5-YEAR VESTING SCHEDULE	
Years of Service	Vesting Percentage
Less than 1	0%
1	20%
2	40%
3	60%
4	80%
5 or more	100%

Loans

You may have one general purpose or residential loan at any time. A loan must be repaid in five years unless it is for the purchase of a primary residence.

STEP FORWARD INTO YOUR FUTURE.

Contact Principal Financial Group at **principal.com** to access your account and update your beneficiary information.

1-800-547-7754

YOUR CONTRIBUTION

BI-WEEKLY PAYCHECK DEDUCTIONS

Medical

PLAN	NON-TOBACCO USER	TOBACCO USER
PPO		
Employee Only	$73.10	$101.08
Employee + Spouse	$146.20	$205.33
Employee + Child(ren)	$131.59	$184.98
Employee + Family	$206.60	$290.50
CHDP		
Employee Only	$31.46	$53.51
Employee + Spouse	$53.43	$101.08
Employee + Child(ren)	$47.50	$91.45
Employee + Family	$86.08	$163.50

LOWER MEDICAL COSTS FOR NON-TOBACCO USERS

If you or any of your covered family members over the age of 18 use tobacco, you will pay more for medical coverage in both options. So if you want to avoid paying more, it's time to kick the habit and/or encourage your family member(s) to do the same.

Need help kicking the habit?

The Tria Health Stop Tobacco by Optimizing Pharmacists (S.T.O.P.) Program makes quitting tobacco easy.

Visit Tria Health online or call 1-888-799-TRIA (8742) for more information.

Dental & Vision

PLAN	BI-WEEKLY CONTRIBUTIONS
Delta Dental	
Employee Only	$3.49
Employee + Spouse	$7.11
Employee + Child(ren)	$6.44
Employee + Family	$8.19
VSP Vision	
Employee Only	$1.97
Employee + Spouse	$3.94
Employee + Child(ren)	$3.56
Employee + Family	$6.34

Supplemental Life and AD&D

Use the rates below to calculate your bi-weekly cost for Supplemental Employee and Spouse Life and AD&D Insurance.

AGE (YOU AND YOUR SPOUSE AS OF JAN. 1[1])	AGE-BASED LIFE AND AD&D RATES (BI-WEEKLY FOR $1,000 OF COVERAGE)
Under 25	$0.041
25-29	$0.049
30-34	$0.058
35-39	$0.064
40-44	$0.080
45-49	$0.112
50-54	$0.180
55-59	$0.269
60-64	$0.404
65-69	$0.706
70-74	$1.048
75+	$1.255
AGE (CHILDREN[2])	
Unmarried child(ren) up to age 26	$0.048 (cost is same, regardless of the number of children you cover)

[1] *Per the plan provisions, if your spouse is employed by the Partnership and is benefits-eligible, you cannot elect coverage for your spouse in this plan.*

[2] *Per the plan provisions, if you and your spouse are employed by the Partnership, only one of you can cover your child(ren) in this plan. Also, if your child is employed by the Partnership and is benefits-eligible, you cannot elect coverage for that child under this plan.*

BI-WEEKLY PAYCHECK DEDUCTIONS

Critical Illness Insurance

LOW PLAN	AGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Non-tobacco user	18-35	$3.39	$5.15	$3.39	$5.15
	36-50	$7.55	$11.38	$7.55	$11.38
	51-60	$15.48	$23.28	$15.48	$23.28
	61-63	$23.98	$36.02	$23.98	$36.02
	64+	$35.01	$52.57	$35.01	$52.57
Tobacco user	18-35	$5.28	$7.98	$5.28	$7.98
	36-50	$12.76	$19.20	$12.76	$19.20
	51-60	$26.33	$39.55	$26.33	$39.55
	61-63	$37.73	$56.65	$37.73	$56.65
	64+	$55.41	$83.17	$55.41	$83.17

HIGH PLAN	AGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Non-tobacco user	18-35	$5.75	$8.68	$5.75	$8.68
	36-50	$14.06	$21.14	$14.06	$21.14
	51-60	$29.94	$44.96	$29.94	$44.96
	61-63	$46.92	$70.43	$46.92	$70.43
	64+	$68.98	$103.52	$68.98	$103.52
Tobacco user	18-35	$9.53	$14.35	$9.53	$14.35
	36-50	$24.48	$36.78	$24.48	$36.78
	51-60	$51.63	$77.50	$51.63	$77.50
	61-63	$74.44	$111.70	$74.44	$111.70
	64+	$109.78	$164.73	$109.78	$164.73

Cancer Insurance

LOW PLAN	BI-WEEKLY CONTRIBUTIONS	HIGH PLAN	BI-WEEKLY CONTRIBUTIONS
Employee Only	$4.47	Employee Only	$7.20
Employee + Spouse	$6.73	Employee + Spouse	$11.49
Employee + Child(ren)	$6.47	Employee + Child(ren)	$9.90
Employee + Family	$8.72	Employee + Family	$14.18

WHO TO CALL

CONTACTS

New Hires, Enrollment Help is a Call Away

Have questions about enrolling? The Energy Transfer Benefit Advocate Center is here to help. Call toll-free at 1-855-562-5847 or email bac.etbenefits@ajg.com. Benefit Advocates are available weekdays from 7:00 a.m. to 6:00 p.m. CT.

Plan Administration

You can also contact one of your plan administrators to find network doctors or ask questions about claims.

The Partnership is committed to protecting the privacy of your health information and complying with laws governing employee benefits. We believe it is important to keep you informed. Please take a few moments to review our legal notices.

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE
Medical	Collective Health	1-855-399-5599	my.collectivehealth.com
Telehealth	Doctor on Demand	1-800-997-6196	doctorondemand.com
Surgery Assistance	Lantern	1-855-200-9512	lanterncare.com
Infertility Benefits	Progyny	1-833-278-1139	progyny.com/education
Prescription Drugs	CVS Caremark	1-800-837-4092	caremark.com
Prescription Drugs - Specialty	CVS Specialty	1-800-237-2767	cvsspecialty.com
Prescription Management	Tria Health	1-888-799-TRIA (8742)	triahealth.com
Dental	Delta Dental	1-800-471-4920	deltadentalins.com
Vision	Vision Service Plan	1-800-877-7195	vsp.com
Health Savings Account (HSA)	PNC Bank	1-844-356-9993	participant.pncbenefitplus.com/login
Flexible Spending Accounts (FSAs)	WEX Health Inc.	1-866-451-3399	benefitslogin.wexhealth.com
Critical Illness & Cancer	Sun Life	1-800-319-5142	sunlife.com/us
Employee Assistance Program (ComPsych)	Sun Life	1-877-595-5284	guidanceresources.com Wed ID: EAPComplete
Mental Health Resource	Headspace	-	headspace.com/app
Life, AD&D	Sun Life	1-800-319-5142	www.sunlife.com/us
Long Term Disability	Sun Life	1-800-319-5142	www.sunlife.com/us
Short Term Disability	Sedgwick	1-855-397-0130	mysedgwick.com/energytransfer
Travel Assistance (Assist America)	Sun Life	1-800-872-1414	assistamerica.com Reference No: 01-AA-SUL-100101
Identity Theft Protection (Assist America)	Sun Life	1-877-409-9597 (US) 1-614-823-5227 (Outside of US)	assistamerica.com Reference No: 01-AA-SUL-100101 Card Patrol: 18327
Commuter Benefit (NJ residents only)	WEX Health Inc.	1-866-451-3399	benefitslogin.wexhealth.com
401(k)	Principal Financial Group	1-800-547-7754	principal.com