LET'S GET STARTED »

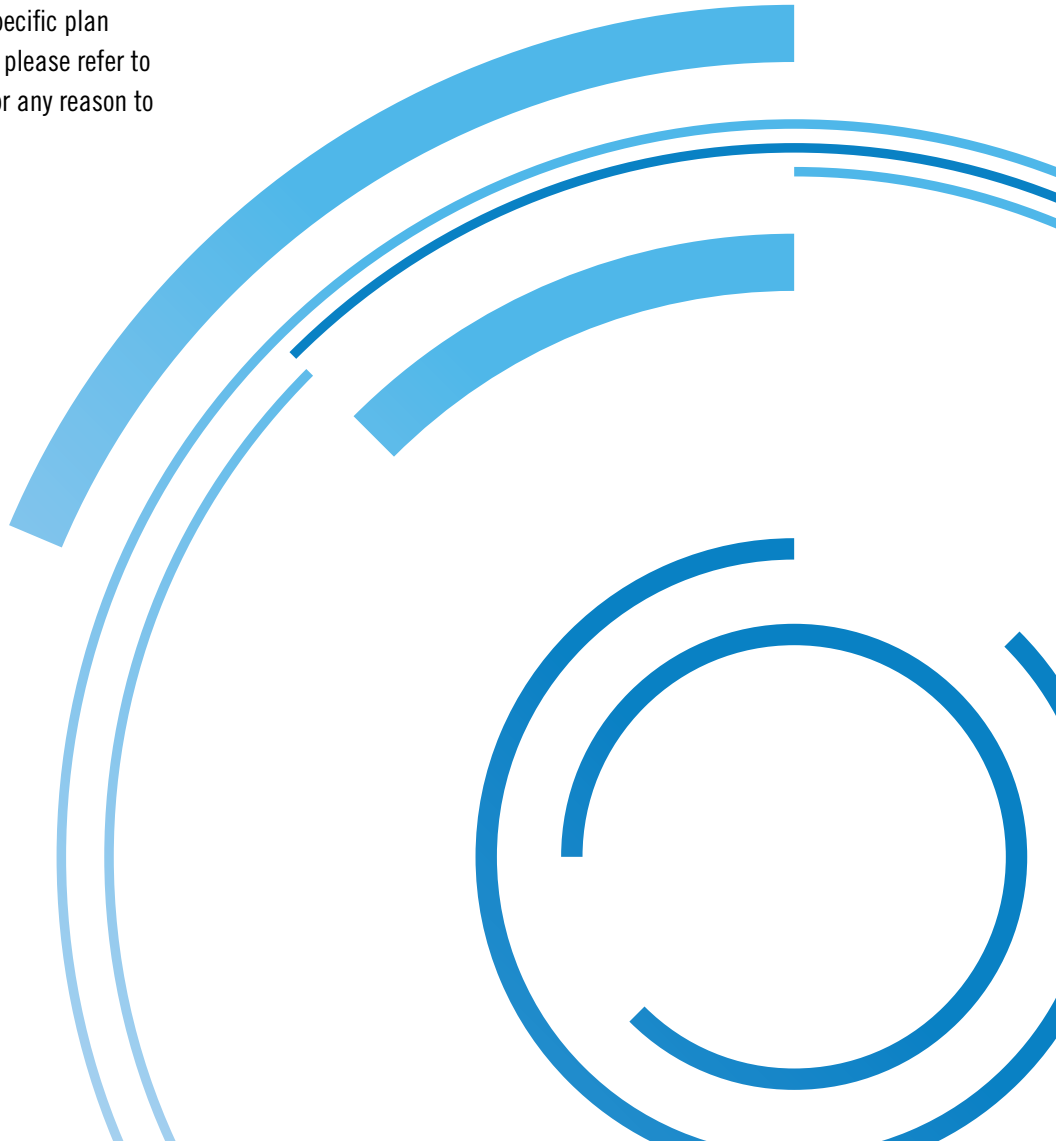
GROWING
TOWARD A GREAT FUTURE

2019 BENEFITS GUIDE

ENERGY TRANSFER®

NOTICE REGARDING THIS COMMUNICATION

This Guide provides only an overview of benefit changes and clarifications effective January 1, 2019. 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**. 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.



HOME

Energy Transfer Benefit Advocate Center
1-855-562-5847
Monday-Friday
7:00 a.m. - 6:00 p.m. CST
ETPBenefits@ajg.com

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.

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 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
- Change in employment status for you, your spouse or your dependent(s)
- Loss of eligibility for dependent(s), child turns age 26
- Change in Medicare status for you or your dependent(s)
- Spouse or dependent 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

Please Note: You must notify the Energy Transfer Benefit Advocate Center of a divorce immediately, but no later than 31 days following the divorce, or you will be required to reimburse the plan for claims paid by the plan on behalf of your ex-spouse.

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

MEDICAL

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

- A Consumer-Directed Health Plan (CDHP), or
- A 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 healthcare 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 deductible, coinsurance and copays.

For specific medical plan details, please refer to the **Benefits Booklet**.

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

Pre-certification Review

Some **services require pre-certification** prior to services being rendered. If you do not receive pre-certification, your treatment may not be covered. Watch the **pre-certification video** for more details on how the pre-certifciation review works.

THE AMERIBEN – BCBS – CVS CONNECTION

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

AMERIBEN

AmeriBen manages all the players that make up your ETP medical coverage. AmeriBen is your main point of contact for finding an in-network doctor, tracking claims, reviewing eligibility, and downloading replacement ID cards.

AmeriBen partners with Blue Cross Blue Shield (BCBS) to use their network of doctors and facilities, allowing you to access some of the best providers nationwide at a lower negotiated cost.

MEDICAL NETWORK

BCBS negotiates with doctors, hospitals and other facilities in their network to get the best value for services. When you are searching for in-network providers, you are looking for those who take BCBS insurance.

As part of your medical benefits, CVS/caremark provides your pharmacy coverage.

PHARMACY COVERAGE

Your medical plan includes prescription drug coverage through CVS/caremark. You will have a separate ID card for pharmacy coverage. For details on your ID card and questions about specific pharmacy coverage, call CVS at (800) 837-4092.

IMPORTANT TIPS

- Confirm your provider has a copy of your ID card.
- When you receive a bill from a provider, it is important that you have an Explanation of Benefits (EOB) from AmeriBen that matches the date of service and charges. If you do not, call your provider to ensure they have billed AmeriBen.
- 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 AmeriBen's Customer Care Center (866) 215-0976.

Pre-certification Review: Certain health services, including hospital admissions, specific outpatient services and surgery, may require precertification prior to services being rendered. This is also referred to as utilization management. If you do not receive pre-certification, your treatment may not be covered. Your ID card provides a list of services that require pre-certification. Please refer to your Benefit Booklet for complete details.

The Midstream Benefits Advocate Center is available to answer your benefit questions Monday through Friday, from 7 a.m. to 6 p.m. CST. Call (855) 562-5847 or email ETPbenefits@ajg.com.

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

PLAN FEATURE	CDHP*	PPO *
Partnership HSA contribution		
Individual	$1,000 (annually prorated based on eligibility date)	None
All other coverage levels	$2,000 (annually prorated based on eligibility date)	
Preventive care services	Plan pays 100%, no deductible or copay	
Deductible		
Individual	$3,750	$1,000
All other coverage levels	$7,500	$2,000
Out-of-Pocket Maximum		
Individual	$3,750	$3,500
All other coverage levels	$7,500	$7,000
Office visits		
Primary Care Physician (PCP) doctor office visit	Plan pays 100%, after deductible	You pay $25 copay**
Specialist	Plan pays 100%, after deductible	You pay $35 copay**
Labs and X-rays	Plan pays 100%, after deductible	Plan pays 80%, after deductible
Inpatient Hospital services	Plan pays 100%, after deductible	Plan pays 80%, after deductible
Outpatient facility	Plan pays 100%, after deductible	Plan pays 80%, after deductible
Emergency care		
Emergency room	Plan pays 100%, after deductible	Plan pays 80%, after deductible
Urgent care	Plan pays 100%, after deductible	You pay $50 copay**
Mental health and substance abuse services		
Office visits	Plan pays 100%, after deductible	You pay $25 copay** for PCP and $35 for specialist
Inpatient	Plan pays 100%, after deductible	Plan pays 80%, after deductible
Outpatient facility	Plan pays 100%, after deductible	Plan pays 80%, after deductible
Physical therapy (up to 18 visits per year)	Plan pays 100%, after deductible	Plan pays 80%, after deductible
Chiropractic services (up to 26 visits per year)	Plan pays 100%, after deductible	You pay $35 copay**

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

*** Copays do not count toward the deductible.*

Medical ID Cards – New enrollees and employees who change medical plans will receive medical ID cards. For all others, ID cards can be ordered online at MyAmeriBen.com or through Customer Care. You will also have the e-card available on the mobile app. You will receive a separate ID card to use at the pharmacy when filling a prescription.

Medical Matchup

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

WELLNESS EXAMS: WHAT YOU NEED TO KNOW!

Q: What is a routine wellness exam?

Expect the basics. An annual wellness exam is a comprehensive exam with your primary care doctor for the sole purpose of preventative care. An annual wellness exam does not include discussion of new problems or 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 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 anannual 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 preventative 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 & avoid surprise billing. Should your wellness exam turn into a diagnostic or problemoriented visit, your doctor has the right to bill accordingly. Avoid doing a wellness exam and a diagnostic visit on the same day. Preventative 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 doctor might want you to have a test because of your age/family history, that's preventive care, but 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.

Q: What can I do to make sure I receive my routine wellness exam benefit?

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

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

Q: What do I do if I think an error has been made on my bill?

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

Q: Where can I get more information on preventive care?

Click here for a list of age-appropriate recommended preventive services. You can learn more about preventive care at Healthcare.gov.

Call: 1-866-215-0976
or
Visit: **www.myameriben.com**

How the CDHP Works

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

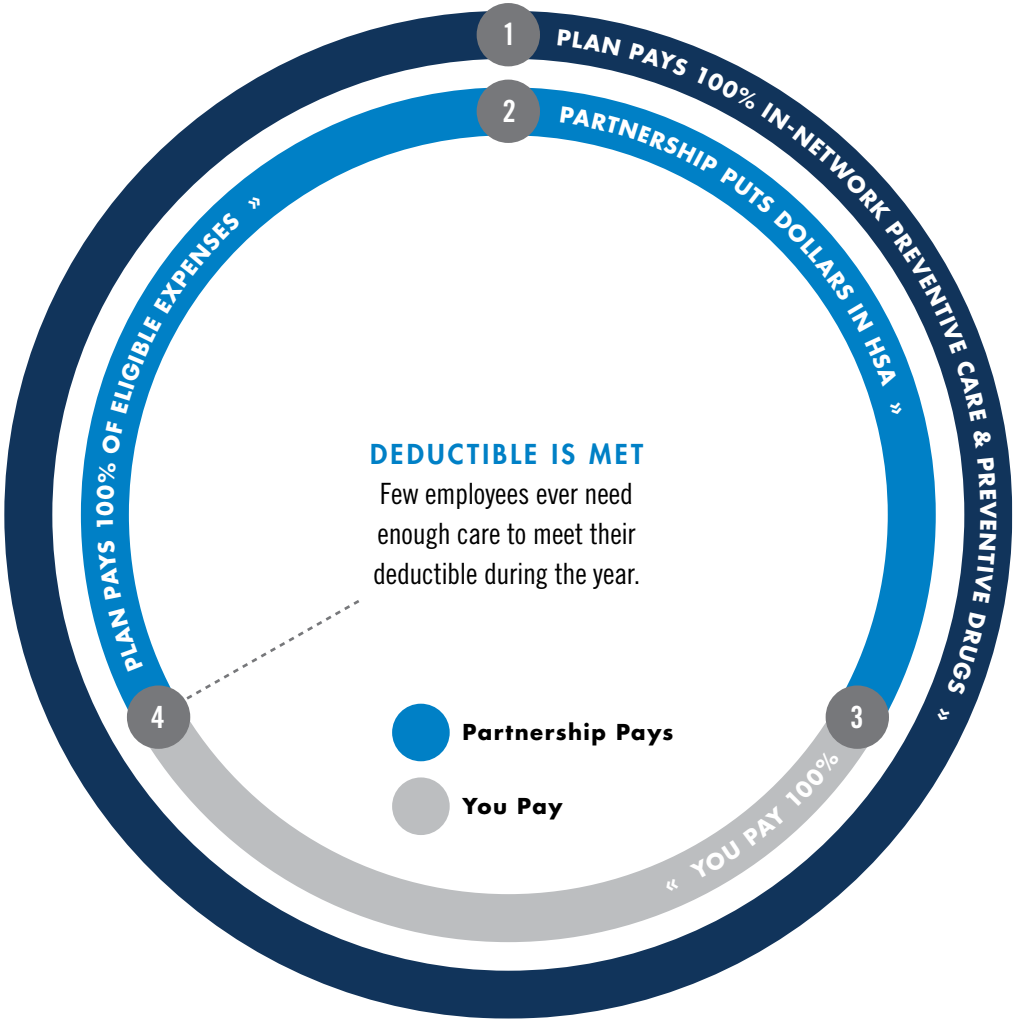
If you choose the CDHP plan, this is how you will pay for care.

1. **THE CDHP PROVIDES FREE PREVENTIVE CARE.**
   When you get in-network, preventive care during the year, like annual wellness exams, kids' check-ups and immunizations, or buy certain qualified preventive drugs, like prenatal vitamins and 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 to help you with medical care during the year, like doctor visits and prescriptions. It's possible 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, 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, then 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 you meet your deductible during the plan year, the Plan will start paying all of the cost for your care for the rest of the plan year. Few employees ever need enough care to meet their deductible during the 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' check-ups, immunizations, some qualified preventive drugs and more).

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.

Want to Learn More?

Check out our Medical Matchup.

	CDHP	PPO
Paycheck Costs	★ **Lower paycheck costs** You pay $216 less each month for non-tobacco Employee + Family coverage. That's a savings of over $2,500 a year!	**Higher paycheck costs** You pay $216 more each month for non-tobacco Employee + Family coverage.
Deductible	**Higher deductible** $3,750 Individual $7,500 All other coverage levels	★ **Lower deductible** $1,000 Individual $2,000 All other coverage levels
Copays & Coinsurance	★ **No copays, pay less coinsurance** You pay nothing after the annual deductible is met; Plan pays 100%.	**Some copays, pay more coinsurance** You pay copayments for primary care doctor and specialist visits and for other services. Plan pays 80% of the cost until the out-of-pocket is met.
Out-of-Pocket Maximum	**May take longer to reach out-of-pocket maximum** $3,750 Individual $7,500 All other coverage levels	★ **Out-of-Pocket maximum is lower** $3,500 Individual $7,000 All other coverage levels
Health Savings Account (HSA)	★ **Yes**	**No**
Partnership Contributions to Health Savings Account	★ **$1,000 Individual** **$2,000 All other coverage levels** The total annual contribution will be prorated based on eligibility date.	**No upfront 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 2019 is: $3,500 Individual $7,000 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 deductible** Deductible does not apply to generic drugs

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

And the winner is the CDHP! As you can see, the CDHP has several advantages—lower payroll deductions, tax-free Partnership dollars to use for medical expenses, and more control for you.

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 1st, the Partnership dollars will be deposited into your HSA account in January. If you are benefits eligible on February 1st or later, your contribution will be prorated based on your eligibility date and a portion ($38.46 or $76.92) will be deposited into your account each pay period. You will receive a Visa debit card that you will use to access your account to pay for medical expenses. You can easily manage your HSA online at HSABank.com.

YOU CAN CONTRIBUTE TOO

Contributing to your Health Savings Account (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 tax-free. Given the tax-free benefits of an HSA, the IRS sets a limit on how much can be deposited to your account each year. You can see how the IRS limit works below:

	2019 IRS LIMIT	2019 PARTNERSHIP CONTRIBUTION	LIMIT FOR YOUR CONTRIBUTIONS
Employee Only coverage	$3,500	$1,000	$2,500
All other coverage levels	$7,000	$2,000	$5,000

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.

IRS HSA Rules

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

DOCTOR ON DEMAND

Out of town or unable to make it to your primary care doctor? Try telehealth through Doctor on Demand. 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 costs per visit varies based on the services need. And, the best part, 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 / $49 CDHP
Psychology	$79 - $199
Psychiatry	$99 - $229

Registration

Register today and be prepared for when an unexpected illness occurs. Go to doctorondemand.com, select BlueCross BlueShield (AmeriBen) and enter the Member ID and Group ID from your insurance card to complete your registration. Each covered member 18 years of age or older will need to create their own account. Then, be sure to download the convenient Doctor on Demand mobile app for on-the-go care.

SURGERYPLUS

Need Surgery? Energy Transfer has a way to help you plan and pay.

Medical care is expensive. Even with health coverage, a surgery often costs thousands of dollars. The Partnership wants you to get the care needed without taking a tough financial hit. That's why we offer a **WAY TO GET SURGERY WITHOUT GOING BROKE.**

It's SurgeryPlus

SurgeryPlus is a free supplement to our medical benefits. It provides many common, outpatient surgeries and surgical procedures to help you from head to toe. The experts at SurgeryPlus negotiate costs before you undergo surgery and only work with board-certified surgeons.As a result, they get an unbeatable price.

What's the catch?

To encourage you to use SurgeryPlus, **THE PARTNERSHIP PICKS UP THE ENTIRE COST AFTER YOU MEET YOUR DEDUCTIBLE.** As an added incentive for employees enrolled in the CDHP plan, the Partnership will make an additional contribution to your HSA based on the type of surgery you need, $250 for minor surgery and $1,000 for major surgery, up to an annual maximum of $1,000.

How Does It Work?

It all starts with a call. As soon as your doctor recommends a covered surgery or a surgical procedure, call SurgeryPlus. The helpful Care Coordinators will walk you through every step of the process and make sure that you do not see any provider bills.

Visit ETP.SurgeryPlus.com, click Register Now and enter the access code ETP. Complete your profile and explore your options. You can also call 1-855-200-9512 to learn more.

SurgeryPlus

PRESCRIPTION DRUGS

When you choose the CDHP or PPO medical option, you also receive prescription drug coverage through CVS/caremark. If you are currently enrolled in a Medical Plan, you can continue to use your CVS ID card. If you are a new enrollee, you will receive a separate ID card with your pharmacy information.

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 100% after deductible	$5 copay
Preferred brand		$35 copay after deductible
Non-preferred brand		$60 copay after deductible
Mail order prescriptions (90-day supply)		
Generic	The plan pays 100% for preventive drugs. For all other drugs, the plan pays 100% after deductible	$10 copay
Preferred brand		$70 copay after deductible
Non-preferred brand		$120 copay after deductible
Specialty Drugs		
Generic	The plan pays 100% for preventive drugs. For all other drugs, the plan pays 100% after deductible	$75 copay
Preferred brand		$75 copay after deductible
Non-preferred brand		$100 copay after deductible

** All coverage amounts assume prescriptions are filled through a CVS/caremark network provider.*

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.

New in 2019. Prescriptions in the PPO plan will be subject to a $150 per person or $300 per 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 maximum out-of-pocket.

PRIOR AUTHORIZATION AND QUANTITY LIMITS

Some newer, more expensive or frequently over-used 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.

QUESTIONS ABOUT HOME DELIVERY?

Review the Prescription Drug FAQs to learn important tips on filling your prescriptions.

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:

- 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.
- 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 2 medication to a Step 1 medication. If a Step 1 medication is not a good choice for you, then 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 pick up.
- 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.

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 covers 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 that 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 the employee's 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, one set 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 $150 every 12 months after $60 copay

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

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

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 Discovery Benefits.

- 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 2019 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 2019 must be filed with Discovery Benefits by March 31, 2020, to be considered for reimbursement. Visit Discovery Benefits for details on filing your FSA claims.

Please note: If you elected an FSA in 2018 and change to the CDHP with HSA for 2019, you must use your 2018 FSA funds by December 31, 2018. If you do not, you will forfeit any funds remaining in your FSA on December 31, 2018.

Paying for Eligible Expenses

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

1. Pay for services and products upfront, 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 Discovery Benefits 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 Discovery FSA Guide for details on paying for eligible expenses.

Please note: You can use your Discover debit card as a credit card to avoid the 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 & DISMEMBERMENT

The Partnership provides a basic level of financial protection for you and your family with Life and Accidental Death & 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 and Supplemental Life for your spouse and your child(ren).

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

	YOU	SPOUSE	CHILD(REN)
Basic Life and AD&D (Partnership paid)	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

Age Reduction Information

Basic and Supplemental Life 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 you 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 The Hartford. Short Term Disability coverage provides you with income replacement if you miss five or more consecutive days of work due to an illness or non-work related injury. You must have been employed by the Partnership for at least 6 months (180 days) 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 STD 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 sick and accrued vacation days must be used to satisfy the elimination period.*

Long Term Disability

The Partnership also provides you Long Term Disability coverage, through The Hartford. 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 ESIS.

GROUP CRITICAL ILLNESS INSURANCE

Critical illness insurance is available to you and your eligible dependents through Allstate Benefits.

Critical illness coverage offers peace of mind if you receive a critical illness diagnosis — 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 Allstate Benefits for more information.

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

Please see the Allstate Benefits Brochure for more details.

GROUP CANCER INSURANCE

Group cancer insurance is available to you and your eligible dependents through Allstate Benefits.

Optional cancer insurance offers peace of mind if you receive a cancer diagnosis. 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	LOW OPTION	HIGH OPTION
Continuous hospital confinement; government or charity hospital; private duty nursing service, extended care facility; at home nursing, or hospice	$100/day	
Radiation, chemotherapy and related benefits		
Radiation/chemotherapy for cancer, blood, plasma, and palettes	$5,000/year*	
Medical imaging	$250/year*	
Hematological drugs	$100/year*	
Surgery and related benefits		
Surgery	$1,500*	
Anesthesia	25% of surgery	
Ambulatory surgical center	$250/day	
Second opinion	$200	
Bone marrow or stem cell transplant (payable once/covered person/calendar year)	• $500 • $1,250 • $2,500	

** Benefits pay for charges/costs up to the amount listed.*

GROUP CANCER INSURANCE (CONTINUED)

PLAN FEATURE CANCER CARE/SERVICE/FACILITY	LOW OPTION	HIGH OPTION
Inpatient drugs and medication	$25/day	
Physician's attendance	$50/day	
Ambulance (per confinement)	$100/confinement	
Non-local transportation	Coach fare or $0.40/mile	
Outpatient lodging ($2,000 limit/year)	$50/day	
Family member lodging and transportation	$50/day* Coach fare or $0.40/mile	
Physical or speech therapy	$50/day	
New or experimental treatment	$5,000*	
Prosthesis (per amputation)	$2,000*	
Hair prosthesis	$25/every 2 years	
Nonsurgical external breast prosthesis	$50*	
Anti-nausea benefit	$200/year*	
Waiver of premium (employee only)	Yes	
Additional Benefits		
Cancer initial diagnosis (one-time benefit)	Not available	$2,000
Wellness		$100/year
Intensive Care • Hospital confinement • Step-down confinement • Air/surface ambulance		• $200 / day • $100 / day • 100% of actual charges/once per confinement

** Benefits pay for charges/costs up to the amount listed.*

Evidence of Insurability (EOI)

EOI is not required for initial or open enrollment. Visit Allstate Benefits for more information.

Cancer benefits are supplemental and do not replace your Medical Plan benefits. Pre-existing condition limitation may apply. Please see the Allstate Benefits Brochure for more details.

SUPPLEMENTAL BENEFITS

The Partnership provides you additional benefits to supplement your health and welfare plans.

Employee Assistance Program (EAP)

Managing daily life can seem overwhelming. The Employee Assistance Program (EAP), brought to you by ComPsych's GuidanceResources®, gives you access to certified professionals who will help you assess the problem and provide you referrals for:

- Counseling services for emotional distress, family issues, and substance abuse
- Financial planning and tax questions
- Legal support
- Work-life solutions such as child and elder care and moving

Call GuidanceResources® at 1-800-327-1850 or log on to guidanceresources.com (**Web ID**: HLF902) for more information.

Travel Assistance

Even the most well planned travel can have unexpected problems. When trouble strikes, Europ Assistance USA is here to help. When you are traveling 100 miles or more away from home, Europ Assistance USA can help you with emergency medical assistance, personal services, or identity theft assistance. They can even assist with pre-trip information such as visa, passport and inoculation requirements.

When you are far away from home, Europ Assistance is just a call away at 1-800-243-6108. ID Number: GLD-09012

SUPPLEMENTAL BENEFITS (CONTINUED)

EstateGuidance®

It is important to document your final wishes to ensure they are honored in the event of your dealth. EstateGuidance® Will Services allows you to create a simple, legally binding Will online free-of-charge. Additional estate planning services are also available for purchase if you choose.

To get started, visit estateguidance.com/wills and use the code WILLHLF.

Funeral Planning Services

Making important funeral decisions after the loss of a loved one is extremely stressful. Help your loved ones by planning in advance. Everest provides online planning tools to help you create a funeral plan. Their advisors are available 24/7 to assist with all funeral planning issues. Everest's services are available for you and your covered dependents.

Call 1-866-854-5429 or log on to everestfuneral.com/hartford and use code HFEVLC to get started.

Beneficiary Assist

Coping with the loss of a loved one can be overwhelming. ComPsych provides counseling services to help with:

- Emotional and grief counseling
- Legal advice
- Financial planning

The plan provides unlimited 24/7phone access and up to five face-to-face sessions for you or your covered dependents. Call 1-800-411-7239 for assistance.

HOLIDAYS

We all need to recharge every now and then. So the Partnership provides you with ten holidays. If the holiday falls on a weekend, the day of observance may vary.

Below are the Partnership holidays:

HOLIDAY	DAY OBSERVED
New Years Day	Tuesday, January 1st
Good Friday	Friday, April 19th
Memorial Day	Monday, May 27th
Independence Day	Thursday, July 4th
Day after Independence Day	Friday, July 5th
Labor Day	Monday, September 2nd
Thanksgiving	Thursday, November 28th
Day after Thanksgiving	Friday, November 29th
Christmas Eve	Tuesday, December 24th
Christmas Day	Wednesday, December 25th

VACATION

We all need time away to refresh so let's see what you have earned based on your completed years of service. You must work 35 or more hours per week to be eligible for vacation benefits.

YEARS OF COMPLETED SERVICE	VACATION WEEKS/DAYS
Under 1 year	2 weeks prorated, based on date of hire
1-4 years	2 weeks / 10 days
5-9 years	3 weeks / 15 days
10-19 years	4 weeks / 20 days
20 or more years	5 weeks / 25 days

Vacation is accrued on a monthly basis.

SICK PAY

On January 1st, employees will receive a bank of sick hours based on work schedule.

Unused sick hours do not carry over to the following year.

SCHEDULE	SICK HOURS
5x8 or 4x10 schedules	40 hours
12 hour shift schedules	48 hours
35-39 hours per week	35 hours

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.

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 The Principal. You may contribute 1% to 75% of your eligible base pay up to the IRS limits. You can make contributions on a pre-tax and a Roth after-tax basis.

IRS CONTRIBUTION LIMITS	
Salary Deferral	Catch-up Contributions*
$19,000	$6,000

** 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 Vice President level and earning $175,000 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%

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

BIWEEKLY Contributions

MEDICAL

PLAN	NON-TOBACCO USER	TOBACCO USER
PPO		
Employee Only	$55.73	$77.05
Employee + Spouse	$111.46	$156.53
Employee + Child(ren)	$100.32	$141.02
Employee + Family	$157.50	$221.47
CDHP		
Employee Only	$19.38	$37.82
Employee + Spouse	$35.72	$71.44
Employee + Child(ren)	$32.32	$64.64
Employee + Family	$57.78	$115.56

Lower medical cost 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?

A Tobacco Cessation Program is available to you with resources and tools like:

- Personal Telephone Wellness Coaching — for help meeting tobacco cessation goals
- Self-Directed Courses — which allow you to work at your own pace to meet your goals

Visit AmeriBen to learn more!

DENTAL & VISION

PLAN	BIWEEKLY 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 biweekly cost for Supplemental Employee Life & AD&D Insurance.

AGE (YOU AND YOUR SPOUSE AS OF JAN. 1[1])	AGE-BASED LIFE AND AD&D RATES (BIWEEKLY 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.

BIWEEKLY Paycheck Costs

CRITICAL ILLNESS INSURANCE

PLAN LOW PLAN	AGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILDREN	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

PLAN HIGH PLAN	AGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILDREN	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

PLAN	BIWEEKLY CONTRIBUTIONS
Low Plan	
Employee Only	$4.47
Employee + Spouse	$6.73
Employee + Child(ren)	$6.47
Employee + Family	$8.72
High Plan	
Employee Only	$7.20
Employee + Spouse	$11.49
Employee + Child(ren)	$9.90
Employee + Family	$14.18

WHO TO CALL

Contacts

HELP IS A PHONE CALL AWAY

Have questions about your coverage? The Energy Transfer Benefit Advocate Center is here to help. Call toll-free to 1-855-562-5847 or send an email to ETPBenefits@ajg.com. Benefit Advocates are available weekdays, from 7:00 a.m. to 6:00 p.m., Central time.

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	AmeriBen	1-866-215-0976	myameriben.com
Telehealth	Doctor on Demand	1-800-997-6196	doctorondemand.com
Surgery Assistance	SurgeryPlus	1-800-200-9512	ETP.SurgeryPlus.com Code: ETP
Prescription Drugs	CVS/caremark	1-800-837-4092	caremark.com
Dental	Delta Dental	1-800-471-4920	deltadentalins.com
Vision	Vision Service Plan	1-800-877-7195	vsp.com
Health Savings Account (HSA)	HSA Bank	1-800-357-6246	hsabank.com
Flexible Spending Accounts (FSAs)	Discovery Benefits	1-866-451-3399	discoverybenefits.com
Critical Illness & Cancer	Allstate Benefits	1-866-828-8501	allstateatwork.com
Employee Assistance Program (ComPsych® GuidanceResources®)	The Hartford	1-800-327-1850	guidanceresources.com Web ID: HLF902
Life, AD&D	The Hartford	1-888-563-1124	thehartfordatwork.com
Disability	The Hartford	1-877-822-3183	thehartfordatwork.com
Travel Assistance (Europ Assistance USA)	The Hartford	1-800-243-6108	thehartfordatwork.com ID Number: GLD-09012
Will Services (EstateGuidance®)	The Hartford		estateguidance.com/wills Code: WILLHLF
Funeral Planning Services (Everest)	The Hartford	1-866-854-5429	everestfuneral.com/hartford Code: HFEVLC
Beneficiary Assist (ComPsych®)	The Hartford	1-800-411-7239	
401(k)	Principal Financial Group	1-800-547-7754	principal.com