# GENESIS ENERGY HEALTH & WELFARE BENEFITS PLAN

## Summary Plan Description

*This Summary Plan Description ("SPD") summarizes the terms of the Genesis Energy Health and Welfare Benefits Plan in effect as of January 1, 2019.  Please keep this document in a safe place and share it with the members of your family covered under the Plan.*

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# YOUR SUMMARY PLAN DESCRIPTION

## Purpose of the SPD

This Summary Plan Description ("SPD") is designed to provide you with a summary of the underlying policies and programs provided for the Genesis Energy Health and Welfare Benefits Plan (the "Plan"), which is sponsored and maintained by Genesis Energy, LLC (the "Company"). The information contained in the SPD is effective as of January 1, 2019.

## How to Use this Document

Your SPD consists of this document, and, in some cases, an additional benefit summary that is incorporated by reference into this SPD. For example, the SPD for your medical benefits consists of this document plus the summary prepared by Blue Cross Blue Shield of Texas for your applicable coverage option. In the event of any inconsistency between this document and the separate benefit summary, this document will control.

## Eligibility

This section describes who can be covered, how to enroll, who pays for what, when coverage begins and ends, and when coverage can be continued in the Company's health and welfare benefit plans and programs.

### Overview

You may enroll for benefits when you are first hired if you are considered a full-time employee of the Company and again for certain benefits each year during an annual enrollment period or if you have a family life change. Some benefits are provided to you automatically at no cost; others you can choose to participate in.

### Your Eligibility

You are eligible to participate in the benefit plans described in this summary on your date of hire as an employee. "You" or "Your", within the context of this SPD, means an employee:

- employed on a regular basis by the Company in the conduct of the Company's regular business,
- regularly scheduled to work at least 30 hours per week, and
- classified by the Company, pursuant to its regular administrative practices or policies, and listed on the Company's payroll records as a common law employee.

The term "employee" shall exclude any other individual, including, but not limited to, any individual who is (i) a leased employee under Internal Revenue Code of 1986, as amended ("Internal Revenue Code") section 414 (n), (ii) a temporary or seasonal employee unless the temporary or season employee meets the requirements under the Affordable Care Act, or (iii) covered under a collective bargaining agreement which is the subject of good faith bargaining, unless the collective bargaining agreement provides for participation in the underlying benefit plan.

The term "employee" shall exclude any individual classified by the Company, in its sole discretion, in a designation which would exclude the person from being considered as an employee under the Company's customary worker classification procedures, regardless of whether such classification is in error.

## Your Family's Eligibility

Certain coverages are available to your eligible family members. Eligible family members include your spouse and your dependent children.

A spouse includes only your legal spouse as determined under applicable state law; provided, however, that such spouse resides in the United States.

Limits for eligible dependent children differ by plan, as shown on the following chart:

**Medical, Dental, Vision, and Flexible Spending Account Plans**

Any child of yours who is:

- Less than 26 years old;
- 26 years or older, primarily supported by you, and incapable of self-sustaining employment because of physical or mental handicap which can be expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months; or
- Subject to a valid Qualified Medical Child Support Order (QMCSO).

Proof of a child's mental or physical handicap and resulting dependence must be submitted to the claim administrator or the Company within 31 days after the date your child no longer qualifies as an eligible dependent, as described above. During the next two years, the claim administrator and/or the Company may, from time to time, require proof of your child's continuing condition. After that, the claim administrator or the Company may require proof no more than once a year;

A child includes:

- a legally adopted child,
- a child placed for adoption with you,
- a stepchild, or
- a child for whom you are the legal guardian.

A "child" includes an unmarried grandchild who meets all of the conditions:

- is your dependent for income tax purposes under Section 152 of the Internal Revenue Code at the time of enrollment in the benefit plan; and
- is subject to being under your legal guardianship under applicable state law.

Any child of divorced parents to whom Internal Revenue Code Section 152(e) applies shall be treated as a dependent of both parents.

Notwithstanding anything in this section to the contrary, a "child" only includes those children for whom benefits can be provided on a tax-free basis under Section 105(b) of the Internal Revenue Code and corresponding guidance. You may be asked to provide proof of your dependent's status from time to time.

If a husband and wife are both eligible to participate in the benefit plans, their children may be considered dependents of either the husband or wife but not of both.

| Life and Accidental Death & Dismemberment (AD&D) |
|---|
| • Any unmarried child of yours from birth to 26 years old<br>• A child includes your legally adopted child, a child placed with you for adoption prior to legal adoption, a stepchild or foster child who depends on you for support and maintenance. |

## Affordable Care Act

Under the Affordable Care Act (ACA), part-time employees will be eligible to enroll in the medical plan if they meet the full-time eligibility requirements under the ACA.

Terms to determine full-time eligibility under the ACA:

- **Standard Measurement Period**: 12 month calendar period, November 1 through October 31, used when evaluating time worked to determine full-time eligibility status for part-time workers
- **Initial Measurement Period**: Calendar period up to 12 months, November 1 through October 31, determined by a new employee's date of hire, used when evaluating time worked to determine full-time eligibility status for part-time workers
- **Standard Stability Period**: 12 consecutive calendar months, January through December, during which a part-time employee who has met the hours of service requirement under the ACA will be classified as a full-time employee for purposes of eligibility and enrollment in the medical plan
- **Initial Stability Period**: for an employee not previously employed for a Standard Stability Period, 12 consecutive calendar months, January through December, during which a part-time employee who has met the hours of service requirement under the ACA to be classified as a full- time employee for purposes of eligibility and enrollment in the medical plan
- **Administrative Period**: time period used to evaluate hours worked and determine full-time eligibility for part-time workers and allow for enrollment in medical benefits during this time period; the administrative period is the time between the end of the standard measurement period and the start of the standard stability period

For ongoing employees who have worked for Genesis for one full Standard Measurement Period, full- time eligibility is determined by whether the employee worked an average of at least 130 hours of service per month by looking back at a defined period of 12 consecutive calendar months, November through October (the Standard Measurement period). If an employee has worked full-time during a Standard Measurement Period, then the employee is treated as full-time during the Standard Stability Period so long as he or she remains employed during that period and regardless of the hours actually worked.

Newly hired employees will be evaluated based on a period of up to 12 consecutive calendar months (Initial Measurement Period). Full-time eligibility is determined if the employee worked an average of at least 130 hours of service per month. If an employee is determined to have met the hours of service requirements during the Initial Measurement Period, then the employee is treated as full-time eligible during the Initial Stability Period so long as he remains employed during that period and regardless of the hours actually worked during the Initial Stability Period.

Hours of service include paid time off due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

The Administrative Period is November through December. To prevent the administrative period from creating a potential gap in coverage, it overlaps with the prior stability period, so ongoing full-time employees will continue to be offered coverage during the administrative period. For example, an employee entitled to coverage for a stability period that is calendar year 2019 will be covered during any administrative period in 2019.

Employees who qualify for coverage under the ACA provisions are eligible to participate in the medical plan for the Standard/Initial Stability Period following the Standard/Initial Measurement Period in which they met the hours worked criteria. Hours worked will be re-evaluated annually during the Administrative Period based on the prior Standard Measurement Period to determine eligibility for the following Standard Stability Period.

If an employee is determined to be full-time eligible under the ACA, eligible dependents include children up to age 26, including natural children, legally adopted children (or children placed for adoption), stepchildren, and foster children, regardless of their marital, student, residency, or financial dependency status, and spouses.

### Qualified Medical Child Support Order (QMCSO)

You can cover your child even if you do not have legal custody if required by a qualified medical child support order. A QMCSO can require the plan to provide medical, dental, and/or health care flexible spending account coverage to a child. It cannot require the plan to provide coverage it would not otherwise provide.

Federal law requires that QMCSOs meet certain form and content requirements in order to be valid. If the plan receives a valid QMCSO and you do not enroll the child, the custodial parent or state agency may enroll the affected child. Any required contribution for this child's coverage will be withheld from your paycheck unless a state agency pays the required contribution.

If you have questions about QMCSOs or would like a copy of the Company's QMCSO procedures, contact the Human Resources Department.

### If You and Your Spouse Work for the Company

- You can each be covered as an employee
- One of you may cover the other as a dependent rather than as an employee
- Only one of you may cover your children for purposes of the medical, dental, vision, FSA plan(s) and/or life insurance plan(s)

## Enrollment

### As a New Employee

You enroll in or decline coverage for most benefits within 31 days of your date of hire where your date of hire is day one (1). You also choose whether to cover your dependents.

You will receive an enrollment package explaining your coverage. Review the information carefully, complete the enrollment form and return it to the Human Resources Department within 31 days of your date of hire. The coverage options you choose remain in effect until the end of the plan year (December 31) unless you make a change because of a status change during the year.

## ID Cards

You will receive identification cards at your home address if you enroll in a medical and/or dental plan. You will receive a debit card at your home address if you enroll in a health care flexible spending account.

## If You Do Not Enroll When First Eligible

If you do not enroll by your deadline as a new employee, you will have only the following the Company paid coverages:

- Basic employee life coverage
- Basic employee Accidental Death & Dismemberment (AD&D) coverage
- Business travel accident coverage
- Short-term (STD) coverage (excluding Genesis Marine vessel workers)
- Long-term disability (LTD) coverage
- Employee assistance program
- Basic long-term care coverage

You will not have coverage in the medical, dental, vision, supplemental life, supplemental AD&D, buy-up long-term care, flexible spending accounts (FSA) or a Health Savings Account (HSA). Genesis Marine vessel workers additionally will not have short-term disability. You will not be able to enroll for coverage in the medical, dental, vision and/or flexible spending accounts until the next annual enrollment period, unless you have a status change. You can enroll in supplemental life, supplemental AD&D, short-term disability (Genesis Mariner vessel workers) or buy-up long-term care coverage anytime during employment.

If you did not elect/change coverage in the supplemental life or disability coverage for yourself and/or your dependents as a new employee and decide to enroll later, the insurance company may require that you complete an evidence of insurability (EOI) form to be approved by Prudential before your coverage goes into effect.

## Annual Enrollment

Generally, each fall, you may elect coverage in medical, dental, vision and flexible spending accounts for the following plan year (January 1 – December 31). Before the enrollment period begins, you will receive information about any changes to plan provisions, the coverage options available for the coming year and your costs.

Generally, the elections you make during annual enrollment take effect the following January 1 and remain in effect until December 31, unless you make a change due to a qualifying status change.

# Naming a Beneficiary

A beneficiary is someone who receives benefits in the event of your death. You need to designate beneficiaries for the following coverages:

- Basic employee life coverage
- Supplemental employee life coverage
- Basic employee AD&D coverage

- Supplemental employee AD&D coverage

To designate a beneficiary, complete and submit your beneficiary designation form to the Human Resources Department. If you name more than one beneficiary, you also must designate what portion of the entire benefit should be paid to each. If you fail to name a percentage, the benefit will be paid in equal shares to each surviving beneficiary.

Beneficiary forms can be obtained from the Human Resources Department.

You are automatically the beneficiary for your dependent's life and AD&D benefits. If you choose to assign benefits, you should contact your legal counsel for guidance.

### Changing Your Beneficiary

Because family situations can change, you should review your beneficiary designations every year. You may change your beneficiary at any time by submitting a new beneficiary designation form. The new designation takes effect on the date you sign and file the properly completed form with the Human Resources Department.

### If You Do Not Name a Beneficiary

If you have not named a beneficiary (or if your beneficiary dies before you), the insurance company may determine who your benefits will be paid to in the instance of your death, in accordance with the hierarchy determined by the insurance company.

### For More Information

Consult the relevant insurance policies for complete information about naming a beneficiary.

## Cost

The following chart shows the different types of coverage available, who pays for the coverage, and how you pay your share of your coverage (pre-tax vs post-tax).

| **Coverage** | **Who Pays** | **Paid Pre-tax vs Post- tax** |
|---|---|---|
| Health Plan | Genesis & You | Pre-Tax |
| Dental Plan | Genesis & You | Pre-Tax |
| Flexible Spending Accounts | You | Pre-Tax |
| Vision Service Plan - Energy | You | Pre-Tax |
| Vision Service Plan – Genesis Mariner Puerto Rico employees | You | Post-Tax |
| Basic Employee Life and AD&D Insurance | Genesis | N/A |
| Supplemental Life and AD&D Insurance (Employee and/or Dependents) | You | Post-Tax |
| Short-Term Disability Plan | Genesis | N/A |
| Short-Term Disability (Genesis Marine Vessel Workers) | You | Post-Tax |
| Long-Term Disability Plan | Genesis | N/A |
| Business Travel Accident Insurance* | Genesis | N/A |
| Basic Long-Term Care Insurance* | Genesis | N/A |

| Supplemental Long-Term Care Insurance (Employee and/or Dependents)* | You | Post-Tax |
| --- | --- | --- |
| Employee Assistance Program (EAP)* | Genesis | N/A |

*These benefits will be treated by your employer as group health plan benefits only to the extent the plan administrator determines such benefits are subject to the special enrollment requirements of the Internal Revenue Code, including, but not limited to, those under HIPAA (as defined in this summary).

You pay for your health, vision, dental coverage, flexible spending account contributions, and Health savings account contributions on a pre-tax basis. This means your contributions are deducted from your pay before federal income tax, Social Security tax and, in most cases, state or local taxes are withheld. This lowers your taxable income, so your overall tax bill is less.

It is important to remember that your Social Security benefit will be based on a slightly lower earnings amount. However, any reductions in your Social Security benefit may be offset in part by the tax saving you receive now by paying for your benefits with pre-tax dollars. Benefits based on your compensation level, such as life insurance, are not affected because they are based on your full pay before any deductions are made.

You pay for any vision (Genesis Marine only), supplemental life and AD&D, and short-term disability benefits with after-tax dollars.

You will be notified of contribution amounts when you first enroll and again each year during the annual enrollment period.

## Imputed Income

If your total life insurance coverage level, for both your basic employee coverage and any supplemental life coverage you elect for yourself, exceeds $50,000 in total, you are taxed on the value of the coverage that is over the $50,000 amount. This amount is added to your W-2 form for tax purposes.

## When Coverage Begins

If you enroll by your enrollment deadline as a new employee, you start participating in health and welfare benefit plans on your date of hire. However, some benefit plans have a waiting period before benefits are payable, such as the LTD plan.

## Changing Your Pre-Tax Coverage

### Status Changes

Generally, your pre-tax benefit elections (medical, dental, vision, and/or flexible spending accounts) are in effect throughout the plan year. However, if you have a status change, you may enroll in certain coverages, change certain coverages, and add or drop dependents. Any change you make to your benefits must be because of and consistent with your status change event, as allowed under applicable laws. A status change includes:

- An event that changes your legal marital status, including marriage, legal separation, annulment, divorce, death of spouse.
- An event that changes your number of dependents, including birth, death, adoption or placement for adoption.
- An event that changes your employment status, or your dependent's employment status, such as termination or commencement of employment, a strike or lockout, a commencement of or return

from an unpaid leave of absence, a change in work site, switching between part-time and full-time status, or having a reduction or increase in hours of employment.

An event that results in a change in your dependent's eligibility for benefits due to age, disability status, or similar circumstance.

- An event that results in a change in your, or your dependent's, residence.

Election changes may also be permitted in other circumstances to the extent provided by law, including, but not limited to, section 125 of the Internal Revenue Code and the corresponding Treasury Regulations.

If you have a status change and want to change your coverage, you must complete a benefit change form (or such other form required by the Human Resources Department) which must be received by the Human Resources Department within 31 days of the date you experience the change (where day 1 is the date of the event). Coverage is effective on the date of the change if the form is received by the Human Resources Department within 31 days of the change.

If the benefit change form is not received by the Human Resources Department within 31 days of the event where day one is the date of the event, you must wait until the next annual enrollment period to initiate the change, or until you experience another status change that would qualify to make the change.

All newborns born to a covered employee or spouse are covered under the medical plan from the date of birth, so long as you enroll them within 31 days of that date. Coverage for newborns who are not enrolled in the plan will end on the 31st day.

## Consistency Rule for Status Changes

You may make a mid-year change in your benefit elections as a result of a status change occurring during a plan year only if the election is on account of the status change, the new election corresponds with the status change, and the status change affects eligibility for coverage under the applicable benefit program ("consistency rule"). The Human Resources Department will determine whether your status change and subsequent election satisfy the consistency rule in accordance with the Internal Revenue Code and other guidance issued by the Internal Revenue Service. Only those individuals affected by the change are eligible for a new election. For example, the birth of a child does not permit you to drop coverage for your spouse.

## Judgment, Decree or Order

You may change your health benefit election during the year if the change is on account of, and consistent with, a judgment, decree or order pursuant to a divorce, legal separation, annulment or change in legal custody requiring health coverage for your child. You may cancel your election for coverage for the child only if health coverage is actually provided to the child by an individual as required by the judgment, decree or order.

## Entitlement to Medicare or Medicaid

You may change your health benefit election to cancel, reduce or begin coverage if you become entitled to, or lose, coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), or Title XXI of the Social Security Act (CHIP) other than coverage consisting

solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). The same rule applies to dependents.

To the extent required by the Employee Retirement Income Security Act of 1974, as amended (ERISA), you may have a status change/special enrollment right if you or your eligible dependent are eligible but not enrolled for coverage under the plan and 1) lose Medicaid or CHIP coverage as a result of loss of eligibility under those programs, or 2) become eligible for assistance under Medicaid or CHIP. Loss of eligibility does not include a loss of coverage for cause (such as a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

You or your dependent must request special enrollment and enroll no later than sixty (60) days from the date of termination of Medicaid or CHIP coverage or sixty (60) days from the date the individual is determined to be eligible for contribution assistance by the state of residence. The effective date of coverage as a result of this type of special enrollment shall be the first day of the calendar month following the plan administrator's receipt of the completed enrollment forms.

## Cost or Coverage Changes

You may be allowed to change your benefit option election due to the following cost or coverage changes:

- Cost Change: If the cost under any of your benefit elections increases or decreases, your paycheck deductions will automatically be changed to correspond to the cost change if the plan administrator determines that such an election change is permitted by the applicable benefit option and the law.
- Significant Cost Decrease: If the cost for a benefit option significantly decreases, the plan administrator may allow all eligible employees, including employees who have elected another benefit option and those who have not previously participated in the applicable benefit program, to elect the benefit option which had a significant decrease in cost.
- Significant Cost Increase: If the cost under any of your benefit elections significantly increases, the plan administrator may allow you to make a corresponding change to your benefit election, including revoking your election for the benefit option that significantly increased in cost. In such case, you may either elect to receive, on a prospective basis, a new benefit option providing similar coverage, or you may drop coverage if no other benefit option providing similar coverage is available.
- Reduction in Coverage: If your elected benefit option has a significant reduction in coverage, such as a significant increase in the deductible, the copayment, or the out-of-pocket maximum, the plan administrator may allow you to revoke that benefit election and elect, on a prospective basis, to receive coverage under another benefit option providing similar coverage.
- Loss of Coverage: If you have a loss of coverage under any of your benefit option elections, the plan administrator may allow you to revoke that benefit election and, in place of that benefit option, to elect another benefit option providing similar coverage or to drop coverage if no other benefit option providing similar coverage is available. A loss of coverage means a complete loss of coverage under the benefit option, including the elimination of a benefit option.

In addition, the plan administrator may treat the following as a loss of coverage: 1) a substantial decrease in the health care providers available under a benefit option; 2) a reduction in the benefits for a specific type of health condition or treatment with respect to which you or your dependents are currently in a course of treatment; or 3) any other similar, fundamental loss of coverage.

- New or Improved Coverage: If a benefit option is added during a plan year, or if an existing benefit option is significantly improved, the plan administrator may allow eligible employees (whether or not they previously made an election under the applicable benefit program or have previously elected the benefit option) to revoke their existing benefit option and make an election, prospectively, for coverage under the new or improved benefit option.
- Another Employer's Plan: A prospective election change under a benefit program that is made on account of a change made under the section 125 plan of another employer may be permitted if: 1) the other employer plan allows its participants to make election changes as provided by law; or 2) the other employer plan allows its participants to make elections for a period of coverage different from the period of coverage under the applicable benefit program.
- Government or Educational Plan: An election to add health coverage, prospectively, may be permitted if you or your dependent loses group health coverage sponsored by a governmental or educational institution, including the following: 1) a State's Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; 2) a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; 3) a state health benefits risk pool; or 4) a foreign government group health plan.

## Special Enrollment Rights Under HIPAA

If you decline health coverage for yourself or your dependents because you already had other health insurance coverage, you may be able to enroll yourself or your dependents in health insurance coverage provided by your employer if you request enrollment within thirty-one (31) days after your other health coverage ends:

1) You meet the following conditions:
    a) the individual had other health benefit plan coverage at the time he became eligible for the benefit plan;
    b) you stated in writing that you were declining to enroll yourself and/or your dependents in the benefit plan because of the other health benefit plan coverage;
    c) coverage being lost was (i) COBRA continuation coverage that was exhausted, (ii) other health benefit plan coverage for which the individual is no longer eligible (for example, by reason of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or (iii) provided by another employer which ceased to pay for it. However, loss of coverage due to a failure to pay premiums will <u>not</u> trigger a special enrollment period; nor will loss of coverage for cause [such as making a fraudulent claim or an intentional misrepresentation] trigger a special enrollment period; and
    d) the individual makes a request for enrollment under the benefit plan within 31 days after losing the other health benefit plan coverage.
    e) If you fail to provide the written statement required under b) above, the benefit plan may not provide special enrollment to you or your dependents.
2) You marry, have a child, adopt a child, or have a child placed for adoption, and make a request for enrollment under the benefit plan within 31 days of such event but only if you have met any applicable waiting period and are eligible for coverage but for your failure to enroll during a previous enrollment period.
3) The term "placed for adoption" means the assumption and retention by you of a legal obligation for the total or partial support of an individual in anticipation of adoption of a child prior to the date on which

such child attains age eighteen (18). A child's status as having been placed for adoption ends on the date that your legal obligation (described above) ends.

4) To the extent required by ERISA, you (or any of your dependents) are "eligible but not enrolled for coverage" under the plan (i) lose Medicaid or CHIP coverage as a result of loss of eligibility under those programs or (ii) become eligible for assistance under Medicaid or CHIP.

If a special enrollment period is offered to a new dependent under the benefit plan, you must also enroll under the benefit plan during that special enrollment period if you are not already participating under the benefit plan.

You have 31 days from the date of the event to request, complete and return the Benefit Change Form to the Human Resources Department for a special enrollment. Contact the Human Resources Department at (800) 284-3365 or email BenefitsConnections@genlp.com to request a Benefit Change Form.

## Changing Post-Tax Coverage

Your post-tax benefit elections, excluding the vision plan for Genesis Marine Puerto Rico employees, can be changed at any time during the year. Your post-tax benefits may include Supplemental Life insurance for yourself, Dependent Life insurance for your spouse and/or children, Supplemental Accidental Death & Dismemberment insurance for yourself and/or your family, Short-Term Disability (Genesis Marine vessel workers) insurance for yourself and/or Supplemental Long-Term Care insurance for yourself and/or your family.

## Changing your HSA Contributions

You may change your HSA contributions at any time during the year.

## Highly Compensated Employees & Key Employees (And Modification of Coverage for All Employees)

Notwithstanding any provision in this summary or the benefit plans to the contrary, the Company or the plan administrator can modify, or reject elections or your (and your related dependents') right to receive benefits under any benefit plan including, to the extent permitted by law, suspend or reduce benefits for you:

- if you are a "highly compensated" or a "key employee" (or similar or related) as determined under various provisions of the Internal Revenue Code at such time and in such manner as it deems necessary or appropriate to ensure that one or more benefit plans comply with the nondiscrimination or other similar requirements under the Internal Revenue Code;
- if you fail to provide information requested by the plan administrator to comply with the information reporting requirements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, 42 U.S.C. Section 1395y(b)(7)-(b)(8) or other applicable law; or
- if you fail to provide information for administrative or other benefit plan purposes, as requested by the plan administrator.

In addition, if you or your dependents continue to be covered under any benefit plan beyond what is permitted or any such individual engages in fraudulent or similar behavior with respect to a benefit plan, the plan administrator or the Company may terminate your and all your dependents' coverage under one or more benefit plans or take such other action as permitted by law as determined by the plan administrator or the Company.

## When Coverage Ends

Your coverage for your benefit plan ends, subject to any additional limitations set forth in the terms of any insurance policy or this summary below, on the earliest of:

- the day on which your employment with the Company terminates as determined from the books and records of the Company, unless you are on an FMLA approved leave of absence;
- the date the benefit plan is terminated;
- the day in which you cease to be in a class eligible for coverage under the benefit plan or the date the plan administrator notifies you that you have failed to provide such forms, information or contributions as the plan administrator may require;
- the date you terminate coverage or decline further coverage under the plan, effective as of the date specified by the plan administrator;
- with respect to any particular coverage benefit, termination of the portion of the option providing that benefit under the benefit plan;
- the latest of the following two dates:
  - the day in which occurs the last day of the FMLA leave; or
  - the day you no longer qualify as an eligible employee and have exhausted all of your sick leave, vacation leave or short-term disability leave as determined by the Company;
- the day in which you enter the military, naval or air forces of any country or international organization or commence USERRA service (or such later date as required by law under an FMLA leave relating to military service or USERRA service (except for temporary call of duty of 30 days or less);
- the date a) a written request to terminate coverage is submitted during an annual open enrollment, effective as of the date specified by the plan administrator or its delegate, or b) of a status change under a benefit plan;
- the day in which you die; or
- the date the plan administrator or the claim administrator determines that you or your dependents have submitted a fraudulent claim and you are notified of such fraudulent claim.

Notwithstanding the above provisions, when the Company is contractually obligated through a severance agreement or employment contract to provide coverage under a benefit plan for a designated time period after termination of employment with the Company, coverage under the benefit plan will be extended in accordance with such contract.

## Dependent Coverage Ends

Dependent coverage will cease, subject to any additional limitations set forth in the terms of any insurance policy or this summary below, for any dependent on the earliest of:

- the date the employee's coverage terminates;
- the date the benefit plan is terminated;
- the day in which the dependent coverage is discontinued under a benefit plan;
- the day in which you cease to be in a class eligible for dependent coverage;
- the day in which the employee no longer has any dependents;
- the day in which the dependent ceases to qualify as a dependent under the benefit plan or fails to provide such forms or information as the plan administrator may require, with the exception of medical which ends on the last day of the month in which the dependent child turns 26;
- in the case of a child for whom coverage is being continued due to mental or physical inability to earn his own living, the last day of the month during which the earliest of the following dates occurs:
    - cessation of such incapacity;
    - failure to furnish any required proof of the uninterrupted continuance of such incapacity or to submit to any required examination; or
    - cessation of support of the dependent by the employee.
- anytime a written request to terminate coverage is submitted during an annual open enrollment or due to a status change under the plan, effective as of the date specified by the plan administrator or its delegate; or
- the date the plan administrator or the claim administrator determines that the dependent has submitted a fraudulent claim and the dependent is notified of such fraudulent claim.

In addition, if a dependent continues to be covered under a benefit plan beyond what is permitted or engages in fraudulent or similar behavior with respect to the benefit plan, the plan administrator may terminate such dependent coverage under the benefit plan or take such other action as permitted by law as determined by the plan administrator.

If your dependent's coverage is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the claim administrator by the plan administrator, refunds will be requested by the plan administrator.

## When Coverage Continues

Under certain circumstances, you may be able to continue some of your benefits.

### Family and Medical Leave

You may continue participating in benefits during a leave of absence that qualifies under the federal Family and Medical Leave Act (FMLA) of 1993, as amended.

If you qualify for and choose to continue coverage, you may pay the active employee rates for your coverage during the leave. The maximum amount of time you may continue benefits through a FMLA paid or unpaid leave is 12 weeks (26 weeks for military reasons). If you do not return to work after your FMLA leave, you may be eligible to continue your benefits through COBRA coverage.

Under the Company's current FMLA policy, you continue to pay the cost for your medical plan, dental plan, and vision plan, flexible spending account contributions and/or Health Savings Account contributions. Any share of your required contributions to these plans (including that which is coverage for dependents) must continue to be paid by you during the FMLA leave period, as adjusted according to any increase or decrease in such required contributions that become effective for similarly situated eligible employees during the period of your FMLA leave. The following procedures will apply to the payment of such required contributions:

- If paid vacation leave is substituted for FMLA leave, the employee's share of premiums will be deducted from the employee's paid leave; and

- If FMLA leave is unpaid, the Company requires that you remit your required contributions to the Company by the first day of each calendar month during FMLA leave, unless the Company and you have voluntarily agreed in writing to another arrangement. With respect to an eligible employee who participates on a pre-tax basis, any payment option on a pre-tax or after-tax basis would be acceptable.

For more information about FMLA leaves please review the Company's FMLA policy.

If your premium payment is postmarked after the last day of the month in which it was due, coverage for you and your dependents under the medical plan shall be terminated for the duration of the FMLA leave unless the Company maintains the coverage in effect.

In order to drop coverage for you (and your dependents, if any) whose premium payment is late, the Company must provide written notification to you that the payment has not been received. Such notice must be mailed to you at least 15 days before coverage is to cease, advising that coverage will be dropped on a specific date at least 15 days after the date of the letter unless the payment has been received by that date. Coverage for you (and your dependents, if any) will be terminated at the end of the 30-day grace period, when the required 15-day notice has been provided, unless the Company does not terminate such coverage.

The Company may recover your share of any premium payments missed by you for any FMLA leave period during which the Company maintains coverage by paying your share after the premium payment is missed.

If you fail to return to work following FMLA leave, any medical plan and non-plan benefit contributions which the FMLA regulations permit the Company to recover are a debt owed by you to the Company. To the extent recovery is allowed, the Company may recover the costs through deduction from any sums due to you (*e.g.*, unpaid wages, vacation pay, etc.), provided such deductions do not otherwise violate applicable federal or state wage payment or other laws. The Company may recover such amounts if you fail to return to work after your FMLA leave entitlement has been exhausted or expires, unless the reason that you do not return is due to:

- The continuation, recurrence, or onset of a serious health condition (as defined in the FMLA Policy) which would entitle you to leave under the FMLA; or
- Other circumstances beyond your control as described in the FMLA regulations.

If you fail to return to work because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the Company from recovering its share of health benefit contribution payments made on your behalf during an unpaid FMLA leave, the Company may require a medical certification of your or the family members' serious health condition.

If the Company requests medical certification and you do not provide such certification in a timely manner (within 30 days), the Company may recover the health benefit contributions it paid during the period of FMLA leave. The amount that the Company may recover is limited to only the Company's share of allowable contributions as would be calculated under applicable state or federal continuation coverage law ("COBRA") (excluding the additional COBRA 2% fee for administrative costs).

### Military Leaves

If you leave the Company to perform uniformed service for a period generally not to exceed five years, special provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) may apply if you return to work at the Company. You must give advance notice of the leave, if possible, and satisfy certain other requirements, including timely return to employment when your military service ends.

You may continue coverage for yourself and your eligible family members in the medical dental, and vision plans for up to 24 months, so long as required contributions are paid. The USERRA period runs concurrently with COBRA. Please consult the plan administrator for more information on your USERRA rights.

## Continuation of Benefits – COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the medical, dental, vision, EAP, and health care FSA programs. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

COBRA continuation coverage can become available to you when you would otherwise lose your coverage. It can also become available to other members of your family who are covered under the medical, dental and health care FSA programs when they would otherwise lose their coverage.

### Employment Agreements

Any continuation coverage benefits for medical, dental, vision, and health care flexible spending accounts under an employment agreement between you and the Company will run concurrently with COBRA continuation coverage, unless specifically addressed in the employment agreement.

### What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the medical, dental, vision and health care spending account programs when such coverage would otherwise end because of a life event know as a "qualifying event". Specific qualifying events are to be offered to each person who is a "qualified beneficiary". A qualified beneficiary is someone who will lose coverage under the medical, vision, dental and/or health care spending account programs because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage may be required to pay for such coverage.

Continuation coverage is the same coverage for the medical, dental, vision and health care spending account benefits that the plan provides to active employees. Each qualified beneficiary who elects continuation coverage will have the same rights under the medical, vision, dental and health care spending account programs as other participants and beneficiaries, including annual enrollment and special enrollment rights.

If you are an employee, you will become a qualified beneficiary if you lose your coverage because either one of the following happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

The spouse of an employee, will become a qualified beneficiary coverage under the plan is lost because any of the following happen:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage as a "dependent child".

## COBRA Continuation Coverage at a Glance

The following chart shows who is eligible for COBRA continuation coverage, under what circumstances, and how long COBRA continuation coverage continues for medical, dental, and/or vision coverage. Special time periods apply to Health Care Spending Account coverage.

| **Qualifying Event*** | **Who is Eligible for COBRA Coverage** | **Duration of COBRA Coverage** |
|---|---|---|
| If you have a reduction in hours | You & your dependents | 18 months |
| If you terminate employment (for reasons other than gross misconduct) | You & your dependents | 18 months |
| If you do not return from an FMLA leave of absence | You & your dependents | 18 months |
| If you become disabled within the first 60 days of COBRA continuation coverage | You & your dependents | Up to 29 months** |
| If you die | Your dependents | 36 months |
| If you become divorced or legally separated | Your dependents | 36 months |
| If you become entitled to Medicare | Your dependents | Up to 36 months** |
| If your dependent is no longer an eligible dependent (due to age limit, divorce, or legal separation) | Your dependents | 36 months |
| If your dependent becomes disabled within the first 60 days of COBRA continuation coverage | You & your dependent | Up to 29 months** |

*Provided the individual was covered the day before the qualifying event.

** If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA continuation coverage for your dependents will last up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for 18 months from the date of your termination of employment or reduction in work hours.

## When Is COBRA Coverage Available?

Generally, COBRA is offered when coverage under the plan ends for medical, dental, vision, EAP, and health care FSA benefits. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the Company will notify the claim administrator of the qualifying event within 30 days of any of these events.

## You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Human Resources Department (or the persons or entities described in the Initial COBRA Notice ("COBRA administrator")) by completing and submitting the required form and documentation of the event within 60 days after the qualifying event occurs. If this process is not followed, any spouse or dependent child who loses coverage may not be offered the option to elect continuation coverage.

## How Is COBRA Coverage Provided?

Once in receipt of the notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of spouses, and parents may elect COBRA continuation coverage on behalf of their children. You will be instructed how to elect and pay for COBRA continuation coverage in the materials you receive at that time. You should review and respond to this information promptly. Except as described below, you will have only one limited window following your qualifying event to elect COBRA. The deadline for electing coverage is 60 days from the later of the date that coverage would otherwise terminate or the date of the COBRA administrator's notification of COBRA rights.

## Duration of COBRA Continuation Coverage

COBRA continuation is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the

employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA coverage can be extended.

- **Disability Extension of 18-Month Period of Continuation Coverage:** If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the Human Resources Department or the COBRA administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

The disability would have to have started at some time prior to the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension so long as one of the qualified beneficiaries qualifies. You must notify the Human Resources Department or COBRA administrator within 60 days after receiving notification from the Social Security Administration in order to receive the additional 11 months.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Human Resources Department or COBRA administrator of that fact within 30 days after the Social Security Administration's determination. COBRA continuation of benefits will end on the earlier of (1) the first day of the month that begins more than 30 days after the final determination under Title II or XVI of the Social Security Act that the disabled individual is no longer disabled, or (2) the date that is 29 months after COBRA coverage began.

- **Second Qualifying Event Extension of 18–Month Period of Continuation Coverage:** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan.

This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the plan as a dependent child but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Human Resources Department or COBRA administrator is notified on the second qualifying event within 60 days of the second qualifying event.

If, after the occurrence of a qualifying event, you, your spouse and/or your dependent children are allowed to continue health care coverage under the plan (whether or not contribution payment(s) are required) beyond the plan's termination of coverage provision for any reason other than to comply with federal law, such continuation period(s) will run concurrently, except as expressly provided by an employment agreement between you and the Company.

### When COBRA Continuation Coverage Ends

COBRA continuation coverage will be terminated before the maximum continuation period described above if one of the following events occurs:

- Any required contribution is not paid in full on time;
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both), after electing continuation coverage;
- The Company ceases to provide any group health plans for its employees; or
- Continuation coverage may also be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

### How Much Does COBRA Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an 11-month extension of coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

### Special Rules for Health Care Flexible Spending Accounts

You or your dependents are also permitted to elect COBRA continuation coverage due to a qualifying event for your health care flexible spending account by continuing contributions on an after-tax basis. The COBRA rules described earlier in this section are similar, except, for example, that the maximum period for which you may continue after-tax contributions to your health care flexible spending account is the remainder of the plan year in which your qualifying event occurred.

Electing COBRA for health care flexible spending accounts gives you or your dependents the benefit of extending the time period for which claims for reimbursement may be incurred. Normally, to be eligible for reimbursement a claim must be incurred while you are covered under and contributing to the health care flexible spending account. If you have not incurred enough expenses at the time of your qualifying event to recover your contributions to the account, then you should consider electing COBRA in order to extend the coverage period long enough to incur claims that would allow for full reimbursement, but not past the end of the year. For this reason, COBRA is only available to you or your dependents if the amount you could be reimbursed exceeds the amount you would have to pay into the account on an after-tax basis.

## COBRA Administrator

PayFlex administers the Company's COBRA coverage. If you have any questions, contact PayFlex Systems USA, Inc. by phone at (800) 359-3921 or logon to www.mypayflex.com.

If you are a COBRA participant, please notify PayFlex if you or your spouse changes address, or if you have a change in family status which impacts your coverage.

# MEDICAL

Medical coverage pays benefits for treatment of an illness or injury. It protects you physically, and it protects you financially from the high cost of medical care. Prescription drugs are covered as part of your medical plan benefits. This section describes generally how the medical plan works and provides a list of covered services and supplies.

### At a Glance

- The plan offers two medical coverage options: the Choice Plus PPO and the Choice Saver HSA.
- The Choice Plus PPO and Choice Saver HSA offer a network of health care providers who have agreed to offer services at a contracted rate.
- The Choice Saver HSA is a "high deductible health plan" that allows you to contribute to a health savings account (HSA).
- You may use the provider of your choice, but if you use an in-network provider you will receive higher benefits than if you choose an out-of-network provider.
- Your contributions for your coverage are deducted from your paycheck on a pre-tax basis.

## Overview

Your medical coverage is a key component to your health coverage. Blue Cross Blue Shield of Texas is the claim administrator and the Company is the plan administrator of this group health plan. Together they determine the payment and types of benefits for your and your dependents' treatment of illness or injury.

## Participation

If you choose to participate in the medical plan, you select one of the following coverage levels:

- Employee only
- Employee & spouse
- Employee & child(ren)
- Employee & family

## Benefit Summaries

Complete information about your medical benefits can be found in the following documents:

- Blue Cross Blue Shield of Texas Choice Plus PPO Benefit Booklet
- Blue Cross Blue Shield of Texas Choice Saver HSA Benefit Booklet

## Important Information About Out-of-Network Providers

Before you visit an out-of-network provider, you should be aware that the plan does not permit you to assign your benefits to third parties. Additionally, you are not permitted to name your provider as your "authorized representative". If your provider's bill exceeds the amount paid by the plan, you may be directly billed by the provider for the balance.

## Medicare

Special rules apply when you are covered by this plan and by Medicare. Generally, this plan is a primary plan if you are a covered full-time employee.

# HEALTH SAVINGS ACCOUNT

The Choice Savings HSA medical coverage option offers you the opportunity to contribute to a separate Health Savings Account ("HSA") administered by Fidelity. You must be enrolled in the Choice Saver HSA coverage option to contribute funds to the HSA account. The HSA is not subject to ERISA.

## At a Glance

- You may also contribute pre-tax dollars each paycheck up to the total allowable amount.
- You aren't required to contribute to an HSA, but participation is encouraged so you can benefit from the tax advantages of this plan.
- Your contributions go into your account and can be used to reimburse yourself for eligible expenses as they occur.
- When you need care, you may choose to pay your claims with your HSA funds or pay the total amount directly out-of-pocket and save your HSA funds for another time.
- HSA funds do not expire, so you can roll them over from year to year and take them with you if you leave the Company.
- The HSA is not subject to ERISA.

## Overview

The Health Savings Account (HSA) is your own bank account that reimburses you for certain eligible medical expenses. Unlike the Flexible Spending Account, you never lose access to the amounts you contribute to your HSA. You can take the HSA with you if you retire from Genesis Energy or terminate your employment.

## Participation

If you choose to participate in the HSA plan, you can select one of the following coverage levels:

- HSA Individual
- HSA Family

**Genesis Energy's Contributions**

- HSA Individual: up to $500 per year
- HSA Family: up to $1,000 per year

Genesis Energy's contribution will be made throughout the year on a pro-rata basis. Employer contributions will be deposited as soon as administratively possible, provided the HSA account is open and ready for funding. Genesis Energy reserves the right to terminate its contributions in future years; however, any contributions that have already been made to your account cannot be forfeited.

**Total 2019 Contribution allowed by IRS**

*(Employee + Company)*

- Individual $3,500
- Family $7,000

If you are age 55 or older, you can contribute an additional $1,000 to your HSA annually in catch-up contributions.

Before you decide to participate in an HSA, here are some additional facts you should know:

- If you are married and your spouse participates in a different HSA-compatible plan, you must each have your own account if you both want to make contributions.
- If you or your spouse participates in a traditional health care flexible spending account or HRA, neither of you will be eligible to contribute to an HSA.
- If you are contributing to the HSA and are 55 and older, you can make up to $1,000 in catch up contributions per year.
- You cannot contribute to an HSA if you are enrolled in Medicare or Medicaid.
- You cannot contribute to an HSA if you are considered a dependent on someone's income tax return (does not include filing jointly with a spouse).
- There is a penalty if you contribute more than the maximum allowed for the year. You may withdraw the excess funds (as taxable income) without penalty up until April 15 of the following year.
- If you use your HSA to pay for non-qualifying medical expenses or for the medical expenses of someone who is not your spouse or federal tax dependent, the reimbursement will be considered taxable income to you and be subject to an additional 20% tax penalty. The reimbursement is not subject to the additional 20% tax penalty if you are age 65 or older or are deemed disabled.
- Need to save more than the limit? You can still use the Health Care FSA; however, it will be administered as a "limited purpose" account. See the "Flexible Spending Account" section for more information.

## Important Information About Your HSA Contributions

Genesis Energy provides contributions to the Health Savings Account (HSA) of each employee who is enrolled in the Blue Cross Blue Shield Choice Saver HSA ("HDHP") medical coverage option. In addition, you can make your own contributions to your HSA up to the annual limits established by the IRS. (Consult your personal tax advisor to learn more about your HSA contribution limits.)

For your convenience, you can elect to have your HSA contributions deducted directly from your paycheck on a pre-tax basis. Otherwise, you can contribute to your HSA on an after-tax basis.

If you are an eligible employee, you must establish your HSA with Fidelity within 30 days of your hire date (or, for existing employees, within 30 days of the date you enroll in the HDHP). To open your HSA, you need to create an account in Fidelity at www.401k.com . If you open your HSA within this timeframe, you will have the opportunity to make HSA payroll deductions and receive the full employer HSA contribution, up to the contribution limits established by the IRS.

If you establish your HSA between 30 and 60 days of your HDHP enrollment, you will receive the HSA contributions you elected to have deducted from your payroll. Failure to open the account within 60 days of the enrollment or your employment is terminated prior establishing an HSA through Fidelity, will result in a refund of your attempted HSA payroll deductions as standard taxable income, subject to withholding and payroll taxes income. Your HSA contribution election will also be cancelled. Lastly, you will also forfeit any employer contributions that would have been deposited if the employee had established the HSA. You will not have the opportunity to make employee contributions or receive employer HSA contributions until the next open enrollment period.

If you have any questions, please contact: Fidelity at https://communications.fidelity.com/wi/fidelity-hsa/ or call 800-544-3716.

# DENTAL

Dental coverage pays benefits for necessary treatment to maintain healthy teeth. This section describes generally how the dental plan component of this plan works and provides a list of covered services and supplies.

### At a Glance

- You may use the dentist of your choice.
- The dental plan provides benefits for a wide range of dental services – from preventative and routine care to treatment of serious dental problems.
- Your contributions for your coverage are deducted from your paycheck on a pre-tax basis.

## Overview

Your dental coverage is a key component to your health coverage. Blue Cross Blue Shield of Texas is the claim administrator and the Company is the plan administrator of this group dental plan.

## Participation

If you choose to participate in the dental plan, you select one of the following coverage levels:

- Employee only
- Employee & spouse
- Employee & child(ren)
- Employee & family

## Benefit Summaries

Complete information about your dental benefits can be found in the following document:

- Blue Cross Blue Shield of Texas Dental Benefit Booklet

# VISION

Vision Service Plan (VSP)is a voluntary option that offers coverage benefits for vision care services and vision care materials. As a participant with vision coverage, you can use benefits at any eye care location, with enhanced benefits when using a VSP preferred provider.

### At A Glance

- VSP has a network of providers who offer discounted fees and wholesale prices for routine eye exams, lenses and frames.
- Should you use a non-network provider, the plan partially reimburses your costs.

## Overview

The vision plan (VSP) is available to help maintain the health of your eyes. This is an optional plan paid for by the employee.

## Participation

If you choose to participate in the vision plan, you select one of the following coverage levels:

- Employee Only
- Employee & Spouse
- Employee & child(ren)
- Employee & family

## Benefit Summaries

Complete information about your vision benefits can be found in the following document:

- Vision Service Plan (VSP) Evidence of Coverage

# FLEXIBLE SPENDING ACCOUNTS

This section highlights how the flexible spending accounts (FSA) works. An FSA can assist you with saving money. By using pre-tax dollars to pay certain eligible health care and dependent care expenses, you save on taxes each year.

### At a Glance

- There are two types of FSAs – the health care account and the dependent care account (the dependent care FSA is not subject to ERISA).
- The health care account is administered as a "limited purpose" account if you are enrolled the Choice Saver HSA medical coverage option.
- You may elect to set aside pre-tax money in one or both accounts through payroll deductions.
- When you incur eligible health care or dependent care expenses, you may reimburse yourself with tax-free money.
- You save by paying less in income tax.

## Overview

The FSA offers you a way to pay certain health and dependent care expenses with pre-tax dollars. Because your contributions are not taxable, you save by paying less in income tax.

There are two accounts – the health care account and the dependent care account:

- The health care account helps you pay for certain medical, prescription drug, dental, vision, and hearing expenses not covered by any health plan.
- The dependent care account helps you pay for eligible dependent care expenses incurred while you and your spouse (if you are married) work.

You fund your accounts through pre-tax paycheck deductions. These funds are credited to your account(s). When you file a claim, you are reimbursed with tax-free dollars from the appropriate account.

You have 14 ½ months to use the money in your FSAs – from January 1 through March 15 of the following year. (If you enter the plan after January 1, you have from the date you entered the plan until March 15 of the following year). If at the end of that time the funds remaining in either account exceed the total amount of your claims, you forfeit the excess amount as required by Internal Revenue Service (IRS) regulations. There are deadlines for incurring expenses and filing claims as outlined in this section.

## Participation

Each year during open enrollment, you decide whether or not to enroll in the account(s) and how much to contribute during the coming year. You can set aside money in one or both accounts. You do not have to be enrolled in a medical or dental plan to participate in either account.

Please refer to the Participation Section for details on eligibility, enrolling, and when coverage begins and ends.

## How Flexible Spending Accounts Work

### Estimate Your Expenses

When you enroll, you determine how much you expect to spend on health and/or dependent care expenses for the coming year. It is important to estimate these expenses carefully, because if you fail to utilize the funds you have set aside within the timeframe specified, you may lose those remaining funds.

### Decide How Much to Contribute

- You decide how much to contribute for the coming year.
- For the health care account, you can set aside up to $2,650 a year.
- For the dependent care account, you can set aside the lesser of:
  - $5,000 ($2,500 if you are married and file a separate federal income tax return),
  - Your earned income for the tax year, or
  - If you are married at the end of the year, your spouse's earned income for the tax year.

Under federal law, if you participate in the dependent care account and your spouse participates in a similar account through his or her own employer, your combined contributions to the account may not exceed $5,000. This limit applies regardless of the number of dependents receiving care.

If you and your spouse file separate income tax returns, the most each of you may contribute is $2,500. In addition, if you are married, your dependent care account contributions may not exceed the annual income of the lower paid spouse.

In general, you may not use the dependent care account if your spouse does not work outside the home. There are two exceptions: if your spouse does not work outside the home and is physically or mentally unable to care for himself or herself, or if he or she is a full-time student.

In these cases, for purposes of calculating the contribution limit, the Internal Revenue Service considers your spouse's earned income to be:

- $250 a month ($3,000 a year) if you have one dependent
- $500 a month ($6,000 a year) if you have two or more dependents

If you participate, it is your responsibility to comply with the federal limits.

### Incurred Expenses

The accounts reimburse you for eligible expenses you or your dependents incur during the 14 ½ months beginning January 1 through March 15 of the following year. Any expense incurred before your enrollment does not qualify for reimbursement. Expenses under the plan are incurred when you are provided with the care or service that gives rise to the expenses, not when you are formally billed or charged, or when you pay for the care.

### Receive Reimbursement

For reimbursement, utilize your FSA debit card or submit a claim form and supporting documentation in accordance with the provisions outlined in this section.

You are reimbursed for the eligible expense with tax-free dollars:

- From the health care account, you are reimbursed up to the total amount you elect to contribute for the year – even if you have not yet had the full amount credited to your account.
- From the dependent care account, you are reimbursed up to the amount in your account on the date your claim is processed.

## If You Terminate Your Employment

Any expense incurred after you terminate employment is not eligible for reimbursement. Only expenses incurred while you are an active employee and contributing are eligible (unless you continue participating in the health care account through COBRA).

## Two Accounts Treated Separately

One additional consideration when estimating your expenses: the health care account and dependent care account are separate. This means you cannot use money deposited in your health care account to pay dependent care expenses, and vice versa.

## Changing Your Contributions

In general, you cannot change the amount of your contributions during the year unless you have a change of status that affects your participation. Any request for change must be consistent with your status change (i.e., disqualification of a dependent for coverage would not be an acceptable reason to increase your deposits). Changes must be made within 31 days of the change in status event. If you do not meet the deadline, you may not make any changes until the next open enrollment period, unless you have another qualifying change in status. Please refer to the Participation section for more details.

## Forfeiture of Contributions

If you do not use the entire balance in your account(s) by the end of the 14 ½ months, the IRS requires you to forfeit the remaining funds. This money is not available for future expenses or a refund.

## A Word about Taxes

FSA contributions reduce your taxable income – meaning you pay less in taxes. Your contributions, as well as the money reimbursed to you, are not subject to federal income taxes, Social Security (FICA) taxes, and most state and local income taxes.

Rules vary, and state and local tax laws are subject to frequent change.

## How These Accounts Can Help You Save

The following chart illustrates the potential tax savings when using a reimbursement account:

| If You Contribute: | Your Tax Savings Could Be: |
|---|---|
| $500 | $113 |
| $1,000 | $226 |
| $3,000 | $679 |

These tax savings are based on a 15% income tax rate and the Social Security (FICA) rate of 7.65%. If your income tax rate is higher, and/or you also pay state and local taxes, you could save even more. Contact your personal tax advisor for more information about the tax savings available to you.

## Effect of Pre-Tax Contributions on Your Other Benefits

Pre-tax contributions reduce the Social Security taxes you pay. Therefore, the eventual Social Security benefit you may be eligible to receive may be reduced. For more information, contact your local Social Security Administration office.

# The Health Care Account

In most cases, you can use the health care account to reimburse your and your eligible dependents' health-related charges that meet all of these conditions:

- Incurred for medical care, including the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body;*
- Incurred while you actively participate in the health care account; and
- Not reimbursed under any other health, dental or vision plan.

*If you are enrolled the Choice Saver HSA, please note that the health care account will be administered as a "limited purpose" flexible spending account. This means that the account will only reimburse qualifying dental and/or vision expenses, as required by federal tax law, until your medical deductible has been satisfied. Once the annual deductible for your Genesis Energy Choice Saver HSA health plan has been met, the account will reimburse all IRS-approved medical expenses.

## Eligible Dependents

In addition to yourself, you can use your health care account to pay out-of-pocket expense for your eligible dependents. This includes your spouse and your unmarried dependent children or stepchildren, so long as the dependents receive over half of their support from you (the health care FSA can be used for all children who meet the ACA's adult child eligibility rules).

## Eligible Expenses

The following are examples of eligible expenses the health care account reimburses. There may be other expenses that qualify for reimbursement. (Remember that if you are enrolled in the Choice Saver HSA medical coverage option, the health care account will reimburse only dental and vision expenses!)

- Acupuncture
- Alcohol or drug dependency treatment and treatment centers
- Band Aids, elastic bandages and wraps
- Dental expenses that are not cosmetic and are not covered or that exceed the dental plan limits
- Charges that exceed usual and customary limits
- Contraceptives
- Hearing care expenses, including those for examinations and hearing aids
- Insulin and diabetic supplies
- Medical and dental deductibles, coinsurance and copays for office visits and prescriptions
- Vision care expenses such as examinations, treatments, eyeglasses and contact lens expenses not covered by a benefit plan
- Wheelchairs, walkers, canes, braces and supports

### Expenses Not Covered

The following are examples of expenses that are not eligible for reimbursement from the health care account:

- Cosmetic treatments or drugs, unless prescribed to treat a congenital defect or accident reconstruction, including:
    - Hair loss treatments or transplants
    - Face Lifts
    - Piercings
    - Teeth whitening or bleaching
    - Health club memberships or exercise classes to promote general health
- Household help, even if recommended by your doctor because you are unable to perform housework
- Individual health or dental insurance contributions
- Over-the-counter drugs and medicines that do not require a prescription from a physician
- Weight loss programs not associated with a diagnosed disease or ailment or dietary supplements taken to promote general health, such as vitamins or herbs
-

The eligible and ineligible expenses listed here are only examples. Other expenses may be eligible for reimbursement. To learn more see IRS Publication 502 at www.irs.gov

## The Dependent Care Account

You can use the dependent care account to pay for many types of dependent care. However, to qualify as an eligible expense, all of the following must be true:

- Care for your dependent(s) must be necessary for you and your spouse to work, look for work, or go to school full time. In other words, expenses are not eligible if they are for services provided while you are out for the evening socially or on vacation.

- The expenses must be incurred during the calendar year plus 2 ½ month extension in which you participate.

- If the care is provided by a day care facility that cares for six or more individuals at the same time, the facility must be licensed.

- Your care provider is not a person you claim as a dependent on your federal tax return (a son or daughter who provides care must be at least age 19). In addition, you must provide your caregiver's name, address and Social Security number or taxpayer identification number when you file for reimbursement. You also must provide this information on your federal income tax return, unless your caregiver is a church or other religious organization.

## Eligible Dependents

An eligible dependent is a child younger than age 13 whom you claim as a dependent on your income tax return. An eligible dependent can also be an older dependent (a disabled spouse, an elderly parent, or any other relative or dependent) who meets all of these requirements:

- Depends on you for at least half of his or her support;
- Is physically or mentally unable to care for himself or herself; and
- Resides with you for more than half the year.

## Eligible Expenses

The dependent care account can be used to pay for IRS-specified dependent care expenses you incur so that you may work or attend school full time. The following are examples of the types of expense for which you can use the dependent care account:

- Dependent care provided in your home, including care provided by a babysitter or housekeeper. The provider may be a relative (provided he or she is not your child under age 19, your spouse or any other person whom you claim as a dependent).
- Dependent care provided outside your home, including care provided in a neighbor's home or in an approved day care center, provided your dependent regularly spends at least eight hours a day in your home. For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for six or more individuals must comply with all federal, state and local regulations governing day care centers.
- Household services, such as housekeeping or maid services, provided they are necessary to run your home for the well-being and protection of your eligible dependent.
- Before and after school programs for children under age 13.
- Day camp services for children under age 13, if the primary reason for being there is the care and well-being of the child and it is custodial in nature, and not educational.

## Expenses Not Covered

Some expenses do not qualify for reimbursement through the dependent care account, including:

- Dependent care expenses incurred before your FSA participation begins.
- Expenses you claim as an after-tax dependent care tax credit on your federal income tax return or expenses paid by any similar reimbursement plan.

- Expenses to attend kindergarten grade or beyond.
- Care provided by a round-the-clock nursing home.
- Services provided by your spouse, your child under age 19, or someone you or your spouse claim as a dependent on your tax return.
- Payments to a housekeeper while you are home from work because of illness.
- Child or dependent care provided while you and/or your spouse are doing volunteer work (even if a nominal fee is paid).
- Transportation expenses to and from the care site.
- Expenses for overnight camp.
- Day care provided by an unlicensed facility if that facility cares for six or more individuals.

The eligible and ineligible expenses listed here are only examples. Other expenses may be eligible for reimbursement. To learn more, see IRS Publication 503 at www.irs.gov

## Applying For Reimbursement

### Health Care Account semente expenses li*The PayFlex Card is similar to a debit card because it electronically accesses your health care account to pay for eligible expenses. All enrollees in the health care account will receive a PayFlex Card. You can use the card at qualified merchant locations where MasterCard is accepted. The PayFlex Card is accepted at health care merchants as well as non-healthcare merchants who have implemented an inventory information approval system (IIAS). Qualified merchants may include physician and dental offices, hospitals, mail order prescription vendors, hearing and vision care providers. As you incur eligible health care expenses, you simply present the PayFlex Card for payment. The system will then validate that your coverage is active and that you have available funds to cover the transaction.*

Using the PayFlex Card is a great way to help relieve you of filing claims. However, it is important that you keep all itemized receipts and Explanation of Benefits (EOBs) in the event the information is requested by PayFlex to comply with IRS regulations. An itemized receipt includes the date of purchase or service, name of merchant or service provider, description of product or service and amount of purchase.

### Filing Claims lex Card is a great wa*For expenses incurred where the PayFlex Card is not used, you may submit a claim for reimbursement online at www.mypayflex.com via Express Claims or complete a paper claim and fax or mail it to PayFlex. Your claim must include any explanation of benefits (EOB) you receive from BCBSTX, and/or an itemized bill for services not covered by insurance, which includes the name of the service provider, cost of the service, description of the service, patient name, and date of service.*

The full annual amount you elect to contribute to your account (less any previous reimbursements) is available for reimbursement, regardless of the amount contributed to date. Contributions continue to be deducted from your pay to cover any claims already fully reimbursed from the health care account.

### Filing Claims l amount you elect to con*As you incur dependent care expenses, you may submit a claim for reimbursement online at www.mypayflex.com via Express Claims or complete a paper claim and fax*

*or mail it to PayFlex. Your claim must include your provider's bill or itemized receipt, as well as your dependent care provider's name, address, and Social Security or federal tax identification number.*

For dependent care account claims, only your current account balance is available. If the dependent care services exceed your account balance, you receive a partial reimbursement. You receive the unreimbursed portion of the claim as you make additional contributions to your dependent care account.

### Filing Deadline

You may file claims any time after you incur the expense. You have until April 30 to file claims for the prior year.

### If a Claim Is Denied

If disagreements arise regarding your claim, every effort is made to resolve them quickly an informally. However, if that is not possible, formal procedures are in place so that you may appeal a decision. Please refer to the Administrative Information section for details on the appeal process for the health care account.

The appeals process described in the Administrative Information section does not apply to the dependent care account. If your claim for reimbursement under the dependent care account is denied, you may appeal the decision to PayFlex by sending a written request for review. Your claim for reimbursement under the dependent care account will be reviewed and you will be notified in writing of a decision and the reason for it.

## EMPLOYEE ASSISTANCE PROGRAM (EAP)

Personal concerns can affect so many aspects of your well-being – physical, emotional, spiritual and even financial. That's why the Company offers you and your family members the EAP – a free counseling and referral service you can turn to when you need help. This section describes generally how the EAP component of this plan works.

### At a Glance

- This service is available 24 hours a day, 7 days a week, 365 days a year.
- The service is paid by the Company. There is no cost to you.
- You can access the EAP website where you can read articles, contact a consultant, listen to audios, take self-assessments, order or download booklets and CDs and more.
- You can also reach a professional consultant using a toll-free number. Your consultant will follow through with whatever support and information you need to answer your question or address your concern.

## Overview

The Employee Assistance Program (EAP), offered through LifeWorks, is available to help you and your eligible family members receive confidential, professional, counseling and referral services. The Company provides this benefit to you at no cost.

## Participation

All employees and their family members may participate.

## How the EAP Works

Confidential, professional assistance is available 24 hours a day, seven days a week by calling (877) 259-3785. The EAP offers assistance with a variety of personal concerns. It can help assess a problem, provide professional counseling services, provide confidential care, educate, provide follow-up care, and refer you to additional resources, if needed. The consultant will ask you questions, discuss the issues, and assess the situation. Your consultant may talk you through the problem and develop an action plan over the phone. Other times, you and the consultant may decide you need more specific information to help you resolve your concern. Your consultant will follow through with the support and information you need to answer your question or address your concern.

If your problem requires in-depth counseling, you and/or your family member may be referred to another professional for additional assistance. Any costs associated with a referral to another professional are your responsibility. The additional services may be covered under your medical plan if you or a family member participates in the Company medical plan. If you or your family member doesn't participate in the Company medical plan, but is covered by another medical plan (for example, a spouse's employer's medical plan), that medical plan may cover some or all of any additional services.

You may also access the LifeWorks website at genesis.LifeWorks.com, with user ID of 'genesis', and password of 'energy'. With access to the website, you can read articles, contact a consultant, listen to audios, take self-assessments, order or download booklets and CDs and more. The site helps you get the answers you want in the format you prefer.

The service is confidential. All contacts via telephone, in person, or via the internet are private unless mandated by law. LifeWorks is mandated to report any instances of harm to self or others, including abuse or neglect of a child or vulnerable adult.

Here are some examples of the things the EAP can help you with:

- Family, including child care referrals, parenting problems, elder day care, serious illness or death of a family member, aging parents, marital difficulties such as divorce, communication facilitation, conflict resolution, domestic violence issues, dual career issues;
- Conflicts at work, such as job dissatisfaction, time management, balancing work and family, conflicts with authority;
- Alcohol or drug abuse;
- Stress or anxiety;
- Depression;
- Financial, such as budgeting or credit management; and/or
- Limited legal advice, such as wills or family law.

## Applying for Benefits

The Company covers the cost of services provided by the EAP. If disagreements arise regarding coverage or services provided to you by the EAP, every effort is made to resolve them quickly and informally. However, if that is not possible, formal procedures are in place so that you may appeal a decision. Please see the Administrative Information section for more information.

# LIFE INSURANCE

This section describes generally how the Company's life insurance benefits work. When you are working, you and your family depend on your paycheck to meet everyday expenses. If you, or your spouse die, your family's financial security may be seriously affected. The Company's insurance benefits are provided to assist in mitigating this financial hardship.

### At a Glance

- The Company provides full-time employees with basic coverage, at no cost to you.
- You may purchase additional coverage for yourself and your dependents at group rates.

## Overview

Life insurance benefits provide financial protection for your survivors in the event of your death.

| **Life Insurance** | **Benefit** |
|---|---|
| Basic Employee Life Insurance | • 3 times employee's base pay for salaried, hourly and day-rate employees*<br>• $150,000 for drivers*<br>• Company paid |
| Supplemental Employee Life Insurance | • Salaried, hourly and day-rate employees may elect 1, 2, 3, 4, or 5 times employee's base pay*<br>• Drivers may elect in $50,000 increments up to $500,000 maximum benefit*<br>• Employee paid |
| Dependent Life Insurance | • Spouse: Increments of $10,000 up to the lessor of $500,000 or the amount the employee has elected for Supplemental Life<br>• Child(ren): Increments of $5,000 up to $25,000<br>• Employee paid |

** The terms "hourly employee", "salaried employee", "day-rate employee" and "driver" are each classified by the books and records of the Company.*

## Participation

Participation in the basic life insurance plan begins on your date of hire. See the Participation section for additional details on eligibility, enrolling, and when coverage begins, ends and continues.

When you are first hired, you may select supplemental life coverage for yourself and your eligible dependents. If you do not enroll when you are first eligible, late enrollment Evidence of Insurability (EOI) requirements apply.

The following life insurance coverages are optional:

- Supplemental Employee Life Insurance
- Dependent Life Insurance

## Benefit Summaries

Complete information about your life insurance benefits can be found in the following document:

- Prudential – Basic Life/AD&D and Optional Life/AD&D Certificate of Coverage – Drivers
- Prudential – Basic Life/AD&D and Optional Life/AD&D Certificate of Coverage – Non-Drivers

# ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

This section describes generally how the Company's AD&D insurance benefits work. If you or your spouse die or become disabled, your family's financial security may be seriously affected. The Company's insurance benefits are provided to assist in mitigating this financial hardship.

### At a Glance

- The Company provides full-time employees with basic coverage, at no cost to you.
- You may purchase additional coverage for yourself and your dependents at group rates.

## Overview

AD&D coverage pays benefits in addition to your life insurance benefits if your death is result of a covered accident. In addition, if you suffer certain accident-related injuries that result in a covered loss, you may be eligible for AD&D benefits.

| AD&D Insurance | Benefit |
|---|---|
| Basic Employee AD&D Insurance | • 3 times employee's base pay for salaried, hourly and day-rate employees*<br>• $150,000 flat benefit for drivers*<br>• Company paid |
| Supplemental Employee AD&D Insurance | • Employee may elect coverage in increments of $15,000, up to $750,000 maximum benefit |
| Dependent AD&D Insurance | • Spouse only = 60% of your coverage amount<br>• Child(ren) only = 15% of your coverage amount on each child<br>• Spouse & Child(ren) = 50% of your coverage amount on your spouse, and 10% of your coverage amount on each child |

** The terms "hourly employee", "salaried employee", "day-rate employee" and "driver" are each classified by the books and records of the Company.*

## Participation

Participation in the basic AD&D insurance plan begins on your date of hire. See the Participation section for additional details on eligibility, enrolling, and when coverage begins, ends and continues.

You may also select supplemental AD&D coverage for yourself and your eligible dependents. The following AD&D insurance coverages are optional:

- Supplemental Employee AD&D Insurance
- Dependent AD&D Insurance

## Benefit Summaries

Complete information about your AD&D benefits can be found in the following document:

- Prudential – Basic Life/AD&D and Optional Life/AD&D Certificate of Coverage – Drivers
- Prudential – Basic Life/AD&D and Optional Life/AD&D Certificate of Coverage – Non-Drivers

# SHORT-TERM DISABILITY – VESSEL WORKERS

This section describes generally how the Company's short-term disability benefits work.

### At a Glance

- Your disability benefits replace a portion of your income if you are unable to work because of an illness or injury.
- Eligible class of employees include Genesis Marine vessel workers.

## Overview

The Short-Term Disability Insurance plan provides financial protection by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. Benefits start after the elimination period.

## Participation

Active full-time Genesis Marine vessel workers working at least 30 hours per week are eligible to elect coverage under this plan. Evidence of insurability does not apply during the initial enrollment period. If you enroll for coverage more than 31 days after the date you are eligible, evidence of insurability will be required. If evidence of insurability is required, coverage will be effective the date Prudential approves your application.

Temporary and seasonal workers are excluded from coverage.

## Benefit Summaries

Complete information about your short-term disability benefits can be found in the following documents:

- Prudential – Short-Term Disability Certificate of Coverage – Genesis Marine Vessel Workers

# LONG-TERM DISABILITY

This section describes generally how the Company's short-term disability and long-term disability benefits work. These disability benefits replace some of your income if you are unable to work because of an illness or injury.

### At a Glance

- You have two types of disability coverage: short-term disability (STD) and long-term disability (LTD).
- Your disability benefits replace a portion or your income if you are unable to work because of an illness or injury.
- The Company pays the full cost to provide these benefits for eligible employees.

## Overview

After you exhaust your short-term disability benefits, you may be eligible for long-term disability benefits. Your disability benefits coordinate with other sources of disability income – such as Social Security and mandated disability programs.

## Participation

Participation in the short-term and long-term disability plan begins on your date of hire.

## Benefit Summaries

Complete information about your short-term and long-term disability benefits can be found in the following documents:

- Prudential – Short-Term Disability Administrative Services Booklet
- Prudential – Long-Term Disability Certificate of Coverage – Drivers
- Prudential – Long-Term Disability Certificate of Coverage – Non-Drivers

# LONG-TERM CARE (LTC) INSURANCE

This section describes generally how the Company's long-term care insurance benefits work. Long-term care insurance provides financial assistance in the event you experience a covered debilitating injury or illness.

### At a Glance

- The Company provides full-time employees with basic coverage, at no cost to you.
- You may purchase additional coverage for yourself and your dependents at group rates.

## Overview

Long-term care insurance benefits provide financial assistance for you and your family in the event you experience a debilitating injury or illness. This insurance is designed to provide coverage for one or more necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home.

The plan provides a fixed dollar monthly benefit if you become disabled and you are receiving care while confined in a long-term care facility, assisted living facility, or receiving professional home care. This benefit is paid to you regardless of whether your actual costs are greater than or less than the benefit amount.

| Long-Term Care (LTC) Insurance | Basic Plan Benefit |
|---|---|
| Long-Term Care Facility Benefit | $3,000 payable per month |
| Assisted Living Facility Benefit | $1,800 payable per month |
| Professional Home Care Benefit | $1,500 payable per month |
| Lifetime Maximum Benefit | $108,000 maximum benefit payable |

## Benefit Summaries

Complete information about your LTC benefits can be found in the following document:

- Unum – Long-Term Care Certificate of Coverage

# BUSINESS TRAVEL ACCIDENT INSURANCE

If you die or are seriously injured in an accident while traveling on business for the Company, your dependents' financial security could be seriously affected. The Company automatically provides you with business travel accident coverage. This section describes generally how the Company business travel accident benefits work.

### At a Glance

- The Company provides full-time employees with coverage, at no cost to you.
- The plan pays a benefit of five times your base pay, or $2,000,000, whichever is less, if your death occurs as a result of an accident while on a Company business trip.
- The plan pays a percentage of that benefit if you suffer a significant loss from an accident that takes place while you are traveling on Company business.

## Overview

Business travel accident coverage provides benefits to you or your designated beneficiary if you are traveling on business for the Company and are involved in an accident that results in your death or serious injury.

## Participation

Participation in the business travel accident plan begins on your date of hire. See the Participation section for additional details on eligibility, and when coverage begins, ends.

## Benefit Summaries

Complete information about your business travel accident benefits can be found in the following document:

- AIG – Business Travel Accident Policy

# LEGAL & ADMINISTRATIVE INFORMATION

This section provides important legal and administrative information about your health and welfare benefits. You'll find important addresses and phone numbers for plan and claim administrators, as well as information about your legal rights when it comes to claims and steps you should take when a claim is denied. This section also provides information about your privacy rights.

## Plan Identification and Funding

This is an employee welfare benefit plan governed by ERISA.

| Plan Name | Genesis Energy Health and Welfare Benefits Plan |
|---|---|
| **Plan Number** | 505 |
| **Plan Year** | January 1 – December 31 |
| **Employer Identification Number** | 80-0321477 |
| **Benefits Provided** | Medical, Dental, Vision, Flexible Spending Accounts, Long-Term Care, Life, AD&D, Short-Term Disability, EAP, and Long-Term Disability |
| **Plan Administration** | The Plan Sponsor serves as the plan administrator under ERISA. Certain administrative function (including claims processing) are delegated to third-party administrators and insurers. |
| **Plan Funding** | Funded through insurance contracts, the general assets of the plan sponsor, and employee contributions |

## Plan Sponsor, Administrator and Agent for Service of Legal Process

The Company sponsors the benefit plans described in this booklet, is the plan administrator, and is the designated agent for service of legal process. You may call the Human Resources Department at (800) 284-3365 or the appropriate third-party administrator or insurance carrier with any questions you may have about these plans. If one of these resources cannot answer your question, you should write to the Human Resources Department at this address:

Genesis Energy, plan sponsor and plan administrator address and phone number:

Genesis Energy, LLC
Human Resources Department
919 Milam, Suite 2100
Houston, TX 77002
(713) 860-2500

## Important Contact Information

| Health & Welfare<br>Benefit Plans | Group Number | Insurance Company or<br>Claim administrator |
|---|---|---|
| Medical<br>(Choice Plus PPO and Choice Saver HSA) | 086304 | Blue Cross Blue Shield of Texas<br>PO Box 660044<br>Dallas, TX 75266-0044<br>(800) 521-2227<br>www.bcbstx.com |
| Health Savings Account | | Fidelity Investments<br>PO Box 770001<br>Cincinnati, OH 45277<br>(800) 835-5097<br>www.401k.com |
| Dental | 086304 | Blue Cross Blue Shield of Texas<br>PO Box 660247<br>Dallas, TX 75266<br>(800) 521-2227<br>www.bcbstx.com |
| Flexible Spending Accounts | 116234 | PayFlex Systems USA, Inc.<br>Flex Department<br>PO Box 3039<br>Omaha, NE 68103-3039<br>(800) 284-4885<br>www.payflex.com |
| Vision Service Plan | 30043154 | Vision Service Plan Insurance Company<br>3333 Quality Drive<br>Rancho Cordova, CA 95670<br>(800) 877-7195<br>www.vsp.com |

| | | |
|---|---|---|
| Life & AD&D Insurance | 45697 | The Prudential Insurance Company of America<br>751 Broad Street<br>Newark, New Jersey 07102<br>(800) 524-0542<br>www.prudential.com |
| Short-Term Disability Insurance | 45697 | The Prudential Insurance Company of America<br>751 Broad Street<br>Newark, New Jersey 07102<br>(800) 842-1718<br>disability.requests@prudential.com |
| Long-Term Disability Insurance | 45697 | The Prudential Insurance Company of America<br>751 Broad Street<br>Newark, New Jersey 07102<br>(800) 842-1718<br>disability.requests@prudential.com |
| Long-Term Care Insurance | 453594 | Unum Life Insurance Company of America<br>2211 Congress Street<br>Portland, ME 04122<br>(800) 227-4165<br>www.unuminfo.com/genesisenergy/index.aspx |
| Business Travel Accident Insurance | 0009154168 | National Union Fire Insurance Company (AIG)<br>A&H Claims Department<br>Post Office Box 25987<br>Shawnee Mission, KS 66225<br>(800) 336-0627 |
| EAP | 6504-0576 | LifeWorks<br>201 17th Street NW, Suite 630<br>Atlanta, GA 30363<br>https://genesis.lifeworks.com/ |

## Keep Your Address Updated

In order to protect your family's rights, you should keep your employer and the plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator. Further you should provide the Company and the plan administrator with such information and evidence as may reasonably be requested from time to time for the purpose of administering the plan.

## Other Participant Responsibilities

Any notices required or permitted to be given under this plan shall be deemed given if directed to such address and mailed by regular United States mail. Notwithstanding anything in the preceding sentence to the contrary, the plan, the Company and the plan administrator may provide any notice electronically, or otherwise, consistent with the requirements of ERISA. Neither the plan administrator nor the Company shall have any obligation or duty to locate you or your covered dependent. In the event that you or your covered dependent becomes entitled to a payment under the plan and such payment is delayed or cannot be made because the current address according to the Company's records is incorrect, the amount of payment, if and when made, shall be that determined under the provisions of the plan without consideration of any interest which may have accrued.

## Changes to the Plan

The Company reserves the right to amend, suspend, or terminate these plans at any time and for any reason.

If any material changes are made in the future, you will be notified about them. Benefits will be paid according to the provisions of each plan.

## Official Plan Documents

If this book inadvertently states anything that disagrees with the official plan documents or insurance contracts that govern each component of these plans, the plan documents or insurance contracts will be used to determine your benefits.

## Claims Process

Claims for health and welfare plan benefits must be filed with the appropriate claim administrators and insurance companies. The procedures for initially applying for plan benefits are found in the relevant benefit program summaries.

As part of the claims administration process, the claim administrators or insurance companies:

- Pay claims for benefits due under the plan
- Provide written explanations of the reasons for denied claims
- Handle claimant requests for reviews of denied claims

The applicable claim administrator has the authority to make the final decision on denied claims with respect to the insured programs under the plan: the long-term disability plan, life and AD&D plans, long-term care plan, and business travel accident plan.

Under the ERISA, you have the right to appeal a denied claim. You must exhaust the plan's claims and appeal processes before filing a lawsuit in federal court.

### Initial Claims Process for the Health Care Account and the EAP

If your claim for benefits is denied, you will receive a written notice from the applicable Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. (See "Important Contact Information" above for the names of the Claims Administrators for the Health Care Account and EAP.) The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your

claim until all information is received. Once notified of the extension, you then have 45 days to provide the requested information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

If your claim for benefits is denied in whole or in part, you or your beneficiary will receive notification regarding the claim denial within the applicable time period described above. This denial notice will include the reasons for the denial, reference to the Plan provision supporting the denial, a description of the Plan's appeals procedures and other relevant information regarding the claim decision.

### How to Appeal a Claim Decision

If you disagree with the Claims Administrator's decision after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. The Claims Administrator will provide you with complete information about how to submit your appeal (including the applicable mailing address or email contact). Please be aware that you may be required to provide the following information:

- The patient's name.
- The plan identification number.
- The date(s) of health care service(s).
- The provider's name.
- The reason(s) you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

### Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

After this first-level review has been completed, you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

### Statute of Limitations for All Benefit Claims

If you wish to file a lawsuit, you must file your action within 12 months of the date you filed your final-level appeal under the applicable benefit program's claims and appeal procedures, unless a shorter deadline is described in a benefit summary or insurance policy.

## Subrogation and Reimbursement

### Overview

The plan does not cover expenses for services and supplies relating to an illness, injury, disability or death as a result of the actions of a third-party that may be liable for such expenses. This exclusion from coverage also

applies to expenses for which payment may be made under any automobile policy, homeowner’s policy, workers’ compensation or similar insurance coverage. If a plan pays or provides benefits for you or your dependents, the plan is subrogated to all rights of recovery which you or your dependent have, and may use your rights to recover money through judgment, settlement or otherwise from any person, organization, or insurer. For the purposes of this provision, subrogation means the substitution of one person or entity (the plan) in the place of another (you or your dependent) with reference to a lawful claim, demand or right, so that he who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

### Right of Reimbursement

If you or your dependent recover money from any person, organization, or insurer for an injury or condition for which the plan paid benefits, you or your dependent agree as a condition of receiving benefits under the plan to reimburse the plan from the recovered money for the amount of benefits paid or provided by the plan. That means you or your dependent will pay to the plan the amount of money recovered by you through judgment, settlement or otherwise from the third-party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the plan.

### Right to Recovery by Subrogation or Reimbursement

You or your dependent agree as a condition of receiving benefits under the plan to promptly furnish to the plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the plan in protecting and obtaining its reimbursement and subrogation rights. You, your dependent or your attorney, if applicable, will notify the plan before settling any claim or suit so as to enable the plan to enforce its rights by participating in the settlement of the claim or suit. You or your dependent further agree not to allow the reimbursement and subrogation rights of the plan(s) to be limited or harmed by any acts or failure to act on your part.

### Refund of Benefit Payments

If the claim administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or was made in error, the plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the claim administrator may deduct any refund due it from any future benefit payment.

### Non-Assignment of Benefits

You cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the plan. However, benefits will be provided to your child if required by a Qualified Medical Child Support Order. In addition, unless you request otherwise in writing in advance of payment, all or a portion of benefits provided by the plan may be paid by the plan directly to the person rendering such service. Any payment made by the plan in good faith pursuant to this provision shall fully discharge the plan.

## Plan Interpretation

The plan administrator has full discretionary authority to interpret and apply the provisions of the plan and this summary. While the summary is intended to be complete and accurate, remember that it is only a summary of the plan's provisions. In interpreting this summary, the plan administrator will rely on the

governing plan document. In the event of any conflict between this summary and its governing document, the plan document will always control. The explanations in the summary cannot alter, modify, or otherwise change the controlling plan document, nor can any rights accrue by reason of any statements or omissions in the summary.

With the exception of denied claims which may be appealed as described in the section entitled claims procedures, the plan administrator's decisions regarding the interpretation of the plan document and summary are conclusive and binding on all persons. The plan administrator may, however, delegate some of its interpretation and decision-making authority to the insurer or claim administrator of the plan. Benefits under this plan will be paid only if the plan administrator or its delegate decides in its discretion that the applicant is entitled to them.

You are encouraged to review the plan documents. You may contact the Human Resources Department so they can make the documents available and arrange a time and place for your review of the documents.

## Insured Benefits

Benefit plans provided pursuant to an insurance policy under which an insurer pays all benefits from the first dollar of claims (i.e. a fully insured policy) will be subject to the following rules:

- Benefits promised under a fully insured policy will be paid only by such insurer; and
- The Company will not be responsible for any benefits which are subject to a fully insured policy.

Benefit plans described in this summary which are fully insured shall be subject to any additional terms, limitations or conditions contained in the applicable insurance policy.

## No Contract of Employment

You should also understand that this summary is not intended to create or to be construed as a contract between the Company and their employees as to any matter, including the provision of benefits described herein. The benefits described in this summary are discretionary and may be changed or terminated at any time for any reason and in any manner not prohibited by law as the Company deems appropriate. Such changes may be made with respect to active employees, former employees, current retirees, future retirees and beneficiaries. Questions of intent, interpretation or application should be referred to the Director of the Human Resources Department. Only a member of the executive management team is authorized to amend the plan and to speak on behalf of the Company on matters relating to this summary and the plan.

## Reservation of Rights

This summary has been prepared to acquaint you with your benefits under the plan and generally describes the provisions currently in effect. Although every effort has been made to assure that this information is accurate, it describes the benefits in general terms and should be used only as a guide. In the event of any ambiguity, discrepancy, inconsistent interpretation or application and/or decision in specific circumstances, the official text or terms of the plan document will govern. Similarly, any oral or written representation that you may receive cannot override, reverse or supplement the provisions of the plan document.

Note that each employee and/or dependent(s) and his/her (their) physician are responsible for making decisions regarding the quality of care and the course of treatment, irrespective of whether the plan provides coverage for such care or treatment or recommends other care or treatment.

## Your Rights as a Plan Participant

As a participant in the plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to:

### Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration ("EBSA").
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary. The plan administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report (Form 5500). The plan administrator is required by law to furnish each participant with a copy of this summary annual report each year.

### Prudent Actions by Fiduciaries

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

### Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, you may file suit in federal court if:

- You request a copy of plan documents or the latest annual report (Form 5500) from the plan and do not receive it within 30 days. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part and you have exhausted the plan's internal claims process. You may also file suit in state court.
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may seek assistance from the U.S. Department of Labor.
- The court will decide who should pay court costs and legal fees. For example, if you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

## Assistance with Your Questions

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