Sunoco GP LLC Health and Welfare Program for Active Employees

Summary Plan Description

2018

Retail Store Employees

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Sunoco GP LLC (the "Company"), provides welfare benefit coverage for eligible employees and their dependents. You may select from among various benefit options based on your employment status and your personal needs.

This document, when taken together with the materials it incorporates and references, constitutes the Summary Plan Description ("SPD") for the Sunoco GP LLC Health and Welfare Program for Active Employees (the "Plan") as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). You should use this document and the materials it incorporates as a reference if you have questions about the Plan. Certain details regarding coverage and the cost of coverage may be found in information provided to you during the open enrollment period (or initial enrollment if you are a newly hired employee).

Certain benefit options under the Plan are self-insured by the Company and administered by a third-party Claim Administrator. The self-insured benefit options are described in summary of benefits booklets issued by the third-party Claim Administrator and describes the terms, conditions and limitations under which that benefit option is administered. Other benefit options are provided by means of insurance, with the terms, conditions and limitations of coverage set forth in an insurance contract and/or certificate of coverage. These documents, as applicable to the benefit option you elect, are sometimes referred to in this booklet as the "Claims Administration Documents." The third-party Claim Administrator or the insurance company, as the case may be, which administers claims for benefits under the benefit option you elect is referred to herein as the "Claim Administrator."

For all benefit options, the applicable Claim Administrator makes all determinations regarding claims for benefits, including with respect to the appeal of denied claims. The Company plays no role in administering claims for benefits but will make decisions on whether an individual is eligible, or is no longer eligible, to participate in the Plan.

The complete terms of coverage are contained in the Sunoco GP LLC Health and Welfare Program for Active Employees Plan Document and the Claims Administration Documents with respect to each benefit option under the Plan. In the case of any discrepancy, the official Plan documents (including the Claims Administration Documents that pertain to the option(s) you have elected) will control.

This SPD does not constitute an implied or express contract or guarantee of employment. While the Company expects the Plan to continue, the Company reserves the right to amend, modify, or terminate the Plan, or any part of the Plan, at any time and for any reason.

The Plan contains an anti-assignment provision. This provision provides that no benefit payable at any time under the Plan shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, provided that a Participant may assign benefits for medical care under this Plan to the provider of that care. None of the following shall be liable for, or subject to, any obligation or liability of any Participant (e.g., through garnishment, attachment, pledge or bankruptcy): the Plan, the Plan Administrator, the Claim Administrator or the Company. Benefits under the Medical Benefit Option of this Plan may not be assigned, transferred or in any way made over to another party by a Participant. Nothing contained in the written description of the Company's Medical Benefit Option shall be construed to make the Plan or the Company liable to any third-party to whom a Participant may be liable for medical care, treatment, or services.

Overview

At open enrollment each year, you are provided with an overview of the available Plan options from which you may choose. Each overview includes the weekly cost of employee, employee plus one dependent, and family coverage. The Company pays a significant portion of the cost of each plan option; you pay the balance. The amount of your contribution depends on the Plan option(s) you select and whether you choose to cover one or more dependents.

Your contributions for coverage are automatically taken from your paycheck with pretax dollars if you are an active employee with taxable earnings in a pay period. This means your share of the cost of coverage is deducted from your paycheck before federal taxes, Social Security, and in some cases, state taxes, are deducted from your pay. However, this may mean a slight reduction in future Social

Security benefits for some employees because pretax contributions are not included in your personal Social Security earnings record for computation purposes.

A list of the Plan options can be found in the section entitled "General Information About the Plan." The specific benefits available, and the limitations, exclusions, and cost-sharing requirements applicable to such benefits, depend on the coverage option(s) you have elected. For a complete description of the benefits covered under the Plan and exclusions from coverage, refer to the Claim Administration Document(s) for the options which are incorporated herein for the purpose of describing benefits. The Claim Administration Document(s) for the Plan option(s) you have selected are available from the applicable Claim Administrator and can also be found on the Company's intranet portal.

Employee Eligibility and Entry Date

Generally, you are eligible to participate in the Plan if you are classified by the Company (or a Participating Affiliate as listed at the end of this SPD) as either a Full-Time Employee or Part-Time Employee ("Eligible Employees"):

- A Full-Time Employee is an Employee who is regularly scheduled to work 35 or more hours per week.

- A Part-Time Employee is an Employee who is regularly scheduled to work at least 30 hours per week, but fewer than 35 hours per week.

Part-Time and Full-Time Employees who are classified as "temporary" Employees, as designated by the Company, are also eligible to participate in the Plan, subject to the limitations in the table at the end of the SPD. Employees who work fewer than 30 hours per week, as well as those persons who are classified by the Company as leased employees or independent contractors, are not eligible to participate in the Plan. Note that the Plan has limitations on which benefit options are available to certain classifications of Eligible Employees. See the table at the end of this SPD for more information.

Generally, the Company determines whether you are regularly scheduled to work the above hours per week and are eligible for coverage by using a measurement period of 12 months. Currently, the standard measurement period for ongoing Employees is the 52 week period that begins with the first day of the pay period that begins with, or includes, October 22nd. This measurement period determines eligibility for benefits for the subsequent plan year (the "stability period"). During the stability period, you cannot lose eligibility for benefits even if your hours drop below 30 hours per week (and you cannot gain eligibility for benefits if your hours go above 30 hours per week, except in limited situations like a promotion).

For example, to determine if you were eligible for coverage during the 2018 plan year, the Company looked at the number of hours you worked during the period from October 2016 through October 2017 (the actual pay period start date in October is dependent on the payroll cycle in which you are paid). If you worked on average at least 30 hours per week during such period, you were eligible to elect benefit options under the Plan effective January 1, 2018 and will remain covered through December 31, 2018, regardless of whether you continued to average 30 hours per week during the 2017 – 2018 standard measurement period.

If you were hired sometime after the standard measurement period began, the Company determines whether you are regularly scheduled to work the above hours per week based on the 12-month period starting on the first day of your first full pay period following your date of hire. If you are determined to have worked on average 30 hours per week during such period, you will be offered coverage beginning on the first of the month following such determination and can retain such coverage for 12 month period. You will then be transitioned from your own measurement period to the Company's standard measurement period.

Entry Date

When you can enter the Plan depends on whether you are paid a salary ("Salary Employee") or paid by the hour ("Hourly Employee"):

- If you are a Salary Employee, you are eligible to participate in the Plan first day of the first month concurrent with or next following the date you become an Eligible Employee.

- If you are an Hourly Employee, you are eligible to participate in the Plan as of the first day of the month following 60 days of employment.

For example, if you are hired on January 15, you are eligible to enroll in the Plan as of April 1. If you are hired on February 1, you also are eligible to enroll in the Plan as of April 1. If you do not enroll in the Plan when first eligible, you must wait until the next open enrollment period to enroll in the Plan (unless you experience a qualifying change in status or special enrollment event at any point during the calendar year).

Eligibility for Dependents

When you enroll in coverage under the Plan, you may elect to cover your spouse and your children. The eligible dependents you can cover under the Plan include:

- Your legally married spouse.
- Your child up to age 26. Your child may be covered until age 26 whether or not he or she is married, resides with you in your home, is your Tax Code Dependent (as defined below) or has other coverage available as the result of his or her (or his or her spouse's) employment. For these purposes, a child includes:
  - A biological child;
  - A legally adopted child or a child placed with you for adoption;
  - A stepchild; and
  - A foster child who is placed with you by an authorized placement agency or by the order of a court.
- An individual under the age of 26, who is under your court-ordered guardianship, provided that such individual (i) is unmarried, (ii) resides with you for the entire year, (iii) is your Tax Code Dependent, and (iv) receives medical treatment in the same geographic area in which you reside.

  The Plan Administrator may prescribe rules by which an individual who must reside with you for the entire year in order to be your eligible dependent may satisfy that requirement even if he or she is a full-time student living away from home. The Plan Administrator may require that you provide proof from time to time of such individual's full-time student status.

Can Coverage be Continued for a Disabled Child?

The Plan will allow your child to continue to be covered as your dependent under the Plan after attaining age 26 if all of the following conditions are satisfied:

- He or she is unmarried;
- He or she is primarily supported by you and is incapable of self-sustaining employment by reason of a mental or physical disability that began before the child attained age 26;
- He or she is not covered under another group Plan; and
- He or she is not eligible for Medicare.

For your child to qualify for dependent status on the basis of a disability, you must, no later than 31 days after your child would otherwise cease to be an eligible dependent (e.g., upon attainment of age 26), submit proof satisfactory to the Plan Administrator of your child's disability and dependency on you for support. Such proof must include that the child's disability commenced prior to his or her attainment of age 26, and a certification that the child is not eligible for Medicare.

Eligibility for dependent coverage following the attainment of age 26 on the basis of a disability will end on the first to occur of (i) the date the child is determined to be no longer disabled

(under the criteria set forth above), (ii) the date the child becomes covered under another group plan, or (iii) the date the child becomes eligible for Medicare. The Plan Administrator (or the Claim Administrator of the Plan benefit option that covers you and your child) may, from time to time, require you to submit proof of your child's continued disability and dependency, and ineligibility for Medicare. Such proof must be satisfactory to the Plan Administrator (or Claim Administrator) and may be requested as frequently as is deemed necessary or advisable by the Plan Administrator or Claim Administrator. Such proof may include that your child submit to an examination by a physician of the Plan Administrator's or Claim Administrator's own choosing. Your failure to cooperate with a request to provide proof of the child's initial or continuing disability and/or dependency, or to provide certification that the child is not eligible for Medicare, may be grounds, without more information, for a determination that the child is, or is no longer eligible for dependent coverage on the basis of a disability.

What is a Tax Code Dependent?

As discussed above, under certain of the requirements for dependent status, you must provide a certification to the Plan Administrator that the individual who you seek to cover is your Tax Code Dependent. This means that the individual is your "dependent" for purposes of the Internal Revenue Code ("Code") by reason of his or her status as your "qualifying child" or "qualifying relative" within the meaning of Section 152(a) of the Code.

Qualified Medical Child Support Order

A QMCSO is a judgment, decree or order issued by a court or appropriate state agency directing that a child be covered under a health plan. Dependent children who must be covered under the Plan in accordance with a QMCSO will be covered beginning on the earliest possible date following the date the order is determined to be a QMCSO by the Plan Administrator or, if later, the date specified in the QMCSO. Coverage will continue until the date or age stipulated in the QMCSO; however, children may not be covered beyond the date they would cease to be eligible for coverage under the ordinary terms of the Plan. You may obtain a copy of the Plan's QMCSO procedures free of charge upon request from the Benefits Department.

Dependent Verification

The Company may require documentation of a dependent's eligibility at any time, and may deny eligibility to any individual if satisfactory proof of eligibility is not timely provided. You are required to submit a Social Security Number for each dependent to be covered under the Plan. The failure to provide a Social Security Number for a dependent will result in such dependent not being covered under the Plan, but will not impact your coverage or coverage for any other dependent for which a Social Security Number is timely provided. In the event a dependent currently has coverage under the Plan and no Social Security Number is provided, such dependent shall lose coverage under the Plan.

Enrollment

When you are first eligible to enroll in the Plan and to elect or waive coverage, you must complete an online election form, or a hardcopy Election Form in the form acceptable to, and provided by, the Plan Administrator. You have 30 days from the date you become eligible to make your election and to submit your online elections or your Benefits Enrollment Election Form. Once you submit your election online or via paper form, your election is final and cannot be changed. You must elect the Plan options in which you wish to be covered, identify any eligible dependents you wish to cover, and authorize the making of pre-tax payroll deductions to pay your share of the cost of coverage you've elected. For employees in the state of Massachusetts, if you choose to waive coverage, you will need to complete an employee HIRD Form, which will be provided by the Company's Human Resources Department.

If you do not elect coverage within the 30-day period, the Company will assume that you have waived coverage, and you will not be allowed to participate in the Plan until the next open enrollment period unless you have a qualifying change in status (see below).

Open Enrollment Period

Open enrollment is held each year for all employees. The annual open enrollment period is typically held in November, with elections effective on January 1 of the following year. During open enrollment you can:

- Enroll in medical, dental and/or vision coverage.
- Stop your medical, dental and/or vision coverage.
- Change from one available medical benefit option to another.
- Enroll eligible dependent(s) who were not previously enrolled.
- Discontinue coverage for dependents who were previously enrolled.

NOTE: You must, while you are actively working and receiving wages from the Company, pay your share of the cost of coverage under the Plan on a pre-tax basis. "Pre-tax" payment means that your taxable income (for federal and certain state income tax purposes) will be reduced by the contribution amount required for the coverage option(s) you elect. Because Social Security benefits are determined on the basis of your taxable income, payment for coverage on a pre-tax basis could slightly reduce the overall Social Security benefits you earn in future years.

Change In Status

As discussed above, you elect to reduce your compensation on a pre-tax basis (for federal income tax purposes) to pay your required contributions for Plan coverage for yourself and your spouse and/or other dependents. In return for this pre-tax advantage, your election to participate in the Plan is generally binding for the year. You may change your election during the year only if you or a family member experience a qualifying "Change in Status" event, and make a timely election to change coverage in a way that is consistent with the Change in Status event. For example, if your spouse loses health coverage from his or her employer during the year, you can elect to change your election and cover your spouse under the Plan, and change your pre-tax contribution election to cover the cost of the additional coverage you have elected.

Except as otherwise provided with respect to a HIPAA Special Enrollment Event (see discussion below), you must make your revised coverage election by filing with the Benefits Department a completed Benefits Enrollment Election Form within 30 days after the date of the Change in Status event. Any change in coverage which is the result of a Change in Status event must be approved by the Benefits Department, and if approved will be effective beginning no later than the first day of the calendar month coincident with or next following the date of the event.

Change in Status. The events that constitute a "Change in Status" include the following:

- Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.
- Events that change your number of eligible dependents, including birth, death, adoption, and placement for adoption.
- A change in employment status by you or your spouse, or other dependent, that causes the individual to become, or cease to be, eligible for coverage under a health plan maintained by his or her employer. A change in employment status for this purpose may include a termination or commencement of employment, a strike or lockout, commencement of or a return from an unpaid leave of absence, or a change in work site.

- Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age.

- Events that permit you to enroll or disenroll your or your dependent's coverage under another employer's health care plan. In such event, you can make a corresponding change in your or your dependent's coverage under the Plan on account of your, or your dependent's, enrollment or disenrollment under another employer's group health plan.

  NOTE: For example, if your child (under the age of 26) gets married and enrolls for coverage under his or her spouse's employer's group health plan, you can make a corresponding election to disenroll your child from coverage under the Plan.

- Events that cause the value or utility of the Plan option you have elected to be substantially curtailed. This can occur, for example, if a Plan option is eliminated, or ceases to be available in the service area where you reside, or if the network of medical care providers available under your Plan option substantially decreases, of if benefits are reduced under your Plan option for a specific type of medical condition or treatment for which you are, at the time the restriction occurs, undergoing a course of treatment.

- If designated by the Plan Administrator as a Change in Status event, if the share of the cost you must pay for the Plan option you have elected should significantly change, you may be allowed to change to a different Plan option.

General Consistency Rules: You may only make an election change pursuant to a Change in Status if your requested election change is consistent with that Change in Status. The Plan Administrator has sole discretion to determine whether a requested change is consistent with the Change in Status. Your election change will be consistent with the Change in Status only if the change is on account of and corresponds with a Change in Status *that affects eligibility for or the cost of coverage under the Plan*.

NOTE: It is possible to experience a Change in Status event, but not have the change affect the cost or value to you of your existing Plan coverage election. In such case, you will not be able to make a change in your Plan option, although you can (if applicable) add or discontinue coverage for an eligible family member under that existing Plan option.

Judgment, Decree or Order. If there is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a Qualified Medical Child Support Order, that requires a change in accident or health coverage for your child or foster child who qualifies as your dependent, you or the Plan Administrator may make an election change to add or drop coverage consistent with the terms and scope of the order.

Entitlement to Medicare or Medicaid. If you or your spouse or dependent becomes entitled to Medicare or Medicaid (other than coverage solely for pediatric vaccines), you may make a corresponding prospective election change to cancel or reduce coverage under the Plan. Similarly, if you or your spouse or dependent loses eligibility for Medicare or Medicaid, you may make a corresponding prospective election change to commence or increase coverage under the Plan.

HIPAA Special Enrollment Events

Certain qualifying life events are considered to be special enrollment events that would allow you to enroll yourself and your eligible dependents in the Plan. A special enrollment event also allows an employee who is already enrolled under the Plan to switch plan options (provided other options are available). The enrollment or change must generally be made within 30 days after the special enrollment event (60 days in certain circumstances noted below).

Special enrollment events include:

- Marriage;
- Birth of a child;
- Adoption or placement for adoption of a child;
- A qualifying loss of coverage under another employer's group health plan by (i) you, if you are not enrolled in the Plan, or (ii) your dependent, if he or she is not enrolled in the Plan. A qualifying loss of coverage under another employer's group health plan is limited to the loss of eligibility for such other coverage (including the exhaustion of COBRA continuation coverage) for reasons other than termination for cause or a failure to pay required premiums for coverage.

  NOTE: A "loss of coverage" under another employer's group health plan includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or a change in residence or worksite so that an individual is outside his or her coverage's service area. A loss of coverage will also occur if the other employer terminates its group health coverage or terminates the contribution it makes toward such coverage.

- Loss of eligibility for coverage in a Medicaid Plan under Title XIX of the Social Security Act or a state Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act; and
- Eligibility for assistance with coverage under a Medicaid Plan or a state CHIP program.

To enroll or change coverage as the result of a HIPAA special enrollment event, you must file a new coverage election by filing with the Benefits Department a completed Benefit Enrollment Election Form within 30 days after the date of the special enrollment event.

NOTE: However, if you or your eligible dependent loses eligibility for coverage under Medicaid or a state's CHIP program or you or your dependent become eligible for state premium assistance under Medicaid or CHIP, you may enroll in the Plan if you notify the Plan Administrator within 60 days of the event.

The enrollment will become effective no later than the first day of the calendar month coincident with or next following the date of the event, provided that you return a completed Benefit Enrollment Election Form to the Benefits Department within the 30-day notification period. However, if you make a timely election following the birth, adoption or placement for adoption of a child, the child's coverage will begin at the time of such birth, adoption, or placement and continue through the end of the 30-day notification period that generally applies. Further, if you make a timely election following your marriage, your spouse's coverage will begin at the time of the marriage. If you do not notify Human Resources within 30 days of the event (60 days in the event of a Medicaid or CHIP-related event as discussed above), you must ordinarily wait until the next Annual Enrollment Period, qualified Change in Status, or special enrollment event to enroll yourself or your dependents in the Plan.

If You Are Disabled

Your medical coverage under the Plan will continue during a disability provided you are receiving short-term disability (STD) or salary continuation with respect to your approved absence due to disability. Generally speaking, your share of the cost of coverage will continue to be deducted from your STD or salary continuation benefits. If your approved leave of absence due to disability continues on an unpaid basis following the end of STD or salary continuation, you must make arrangements satisfactory to the Plan Administrator to pay your share of the cost of coverage. (See also "If You Take a Leave of Absence," below.)

If You Take a Leave of Absence

Your coverage under the Plan will continue while you are on an approved leave of absence or FMLA, provided you pay the required contributions directly to the Company. See the Company's Leave of Absence Policy for more information on approved leaves of absence. If your approved leave of absence is unpaid and you would like to continue your coverage, you must make arrangements satisfactory to the Plan Administrator to pay your share of the cost of coverage with post-tax funds.

If you fail to timely make the required contributions for coverage, your coverage will be terminated effective as of the end of the last period for which your contribution was timely made. If you return to work, coverage will be reinstated, although the Plan Administrator will first require that you pay, or make satisfactory arrangements to pay, all past due contributions for periods during which coverage was provided.

NOTE: Your loss of coverage because you fail to pay your share of the cost of coverage during an unpaid leave of absence is not a COBRA qualifying event and you will not be able to elect COBRA continuation coverage. For more information about COBRA, see the "COBRA Continuation Coverage" section of this SPD.

Military Leave

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), if you are absent from work for fewer than 31 days in order to fulfill a period of duty in the Uniformed Services (U.S. armed forces, Active, Reserved, and National Guard, U.S. Public Health Service Commissioned Corps. or the National Disaster Medical System) you will have the opportunity to continue coverage under the Plan at a cost no greater than the cost charged to an active employee. If you are absent in the Uniformed Services for more than 31 days and would lose health coverage under the Plan as a result, you will be given the opportunity to elect COBRA continuation coverage as provided in the "COBRA Continuation Coverage" section below. However, to satisfy the requirements of the Veterans Benefits Improvement Act of 2004 ("VBIA"), for purposes of the COBRA continuation coverage, any reference to "18 months" of continuation coverage or "the 18-month coverage period" shall be replaced with "24 months" and "the 24-month coverage period" as appropriate. Coverage pursuant to the terms of USERRA, VBIA and COBRA continuation coverage will run concurrently. If you are discharged before your 24 months of COBRA continuation coverage ends, and you plan on returning to work for the Company, you must notify your immediate supervisor and the Benefits Department within 30 days of your discharge.

If You Commit a Felony

Employees or their dependents imprisoned or convicted of a felony are not eligible for benefits under the Plan.

When Your Coverage Ends

Subject to available COBRA continuation coverage, your coverage under the Plan ends upon the first to occur of the following events:

- The last day of the month in which you leave the Company or otherwise cease for any other reason (e.g., retirement, termination of employment, lay off, reduction of hours, or cessation or expiration of an approved leave of absence without a timely return to work) to be an eligible employee.

- The date as of which you waive coverage (or are deemed to waive coverage) under the Plan, subject to the "Change in Status" rules under the Plan.

- The date you become eligible to participate in the Energy Transfer Partners GP, L.P Health and Welfare Program for Active Employees.

- If you fail to make timely payment of the contribution required for coverage (including any grace period), the last day of the month in which you last made a timely contribution.

- The date of your death.

- The date as of which your coverage is suspended by the Plan Administrator for failure to repay upon demand an overpayment or payment made in error, or is suspended for misrepresentation or fraud in connection with eligibility for coverage or a claim for benefits.

- The date as of which your coverage is suspended by the Plan Administrator for failure to cooperate with the Plan Administrator or Claim Administrator with respect to enforcing the Plan's coordination of benefits rules, or in determining, verifying or enforcing the Plan's right to subrogation or reimbursement.

- The date you enter the armed forces of the United States or any country, subject to any right you may have to continue coverage (see the discussion of Military Leave under the section entitled "If You Take A Leave of Absence").

- The date the Plan is terminated or amended to terminate coverage with respect to the employee group of which you are a member.

When Your Dependent's Coverage Ends

Subject to any available COBRA continuation coverage, coverage for your dependent will end on the first to occur of the following events:

- The date your coverage under the Plan ends.

- The last day of the month on which your dependent, if a child, ceases to satisfy the Plan's definition of a dependent.

- The last day of the month you elect to discontinue coverage for your dependent, subject to the "Change in Status" rules under the Plan.

- The day on which your spouse ceases to be your spouse by reason of divorce or legal separation.

- The last day of the month in which you die.

- The date as of which the dependent's coverage is suspended by the Plan Administrator for failure to cooperate with the Plan Administrator or Claim Administrator with respect to enforcing the Plan's coordination of benefit rules, or in determining, verifying or enforcing the Plan's right of subrogation or reimbursement.

- The date as of which the dependent's coverage is suspended by the Plan Administrator because of your, her or his failure to repay upon demand an overpayment or payment made in error, or is suspended for misrepresentation or fraud in connection with eligibility for coverage or a claim for benefits.

- The date the Plan is terminated or amended to eliminate dependent coverage with respect to the class of individuals of which your dependent is a member.

Coordination With Medicare (Medicare Secondary Payer Rules)

If you are an active employee and you or your spouse is over age 65 or otherwise eligible for Medicare, the Plan is the primary payer (that is, it pays first), and Medicare is the secondary payer in accordance with Medicare Secondary Payer rules. The exception to this rule is in the event that you or your dependent are covered under the Plan and have End Stage Renal Disease ("ESRD"). During the

ESRD coordination period set by Medicare, the Plan will be primary and Medicare will be secondary. After the ESRD coordination period, Medicare will be primary and the Plan will be the secondary payer of benefits for the individual with ESRD.

A person is "eligible for Medicare" if he or she:

- is covered under Medicare;
- is not covered under Medicare because of:
- having refused it;
- having dropped it;
- having failed to make proper request for Medicare.

Coverage will not be changed at any time when compliance with federal law requires this Plan's benefits for a person to be determined before benefits are determined under Medicare.

Recovery of Payments – Subrogation and Reimbursement

The Plan has a method to prevent or correct duplicate payments. Whenever any "Responsible Party" has caused or contributed to an illness, injury or condition and the Plan has paid or could pay benefits for expenses incurred in connection with that illness, injury or condition, the Plan has a right to recover for those benefits. These recovery rights apply with respect to coverage from any other source, including, but not limited to, any compensation fund, uninsured motorist coverage, underinsured motorist coverage, medical payments coverage, personal umbrella coverage, workers compensation coverage, no-fault automobile insurance coverage, or first party insurance coverage. They also apply with respect to any third party responsible, in whole or in part, directly or indirectly, for an event that causes or contributes to your or your dependent's illness, injury or condition.

The Plan may exercise its recovery rights either through subrogation or reimbursement.

Definitions

As used throughout this section:

The term Responsible Party means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term Responsible Party includes the liability insurer of such party or any Insurance Coverage.

The term Insurance Coverage refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile Insurance Coverage, or any first party Insurance Coverage.

The term Covered Person includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan participant or person entitled to receive any benefits from the Plan.

Subrogation

Subrogation allows the Plan to substitute for you or your dependent and assume your right to recover from any party who is actually, possibly, or potentially responsible for making payments on account of the illness, injury or condition or the event that caused the illness, injury or condition. For example, the Plan may recover for benefits it has paid by filing a lawsuit. If you file a lawsuit, the Plan may intervene in that litigation at any time.

Reimbursement

Reimbursement allows the Plan to recover and be reimbursed for all amounts that are paid to you or made on your behalf from any source as the result of an illness, injury or condition. It also allows the Plan to offset future benefits by the amount of other payments, to the extent the

Plan has not already recovered them. As with subrogation, the Plan has the right to initiate a lawsuit or other proceeding or to intervene in a proceeding to exercise or preserve its reimbursement rights.

The Plan may exercise its subrogation and reimbursement rights if you or any of your dependents becomes or may become entitled to acquire a direct or indirect interest in or otherwise receive amounts paid by a party on account of any event or circumstance that causes or contributes to your or your dependent's illness, injury or condition. These rights apply to all settlements, judgments, actions and amounts regardless of any and all of the following:

- Whether a party admits liability.
- How any amounts that are or may become payable to you or your dependent are characterized. Accordingly, these rights apply to amounts that are designated as payment for medical or dental expenses, or designated for any other purpose, including but not limited to compensation for pain or suffering, non-economic damages, or general damages only. These rights also apply to amounts that are not given any particular designation at all.
- The source or form of payment.
- The legal expenses that are or may be incurred in obtaining such payments.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that the Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Cooperation

You and your covered dependents are required to fully cooperate with the Claim Administrator with respect to its efforts to recover benefits. You, your covered dependents and your representatives may not do anything to prejudice the Plan's rights to subrogation and reimbursement and you must provide the Plan with all information it deems necessary to protect

its rights of subrogation and reimbursement. You or your representative must promptly, and in any event within 30 days, notify the Claim Administrator in writing of:

- The date that you send any notice of the intent to pursue or investigate a claim to recover damages or obtain compensation due to an illness, injury or condition.
- Any claim that you file against any other party.
- Any discussions, proceedings, settlements, payments or other matters relating to such a claim.
- The entry of any judgment, award or decision that involves or refers to any expense that has been paid by the Plan or will be submitted to the Plan for payment.

You may not settle any claim with respect to which the Plan has or might have recovery rights without the Claim Administrator's consent and you must promptly notify the Claim Administrator, in writing, of settlement discussions and the offer of a settlement.

Failure to provide this information, failure to cooperate or otherwise assist the plan in pursuit of its subrogation rights, or failure to reimburse the Plan from any settlement or recovery obtained by you or the other Covered Person, may result in the termination or suspension of health benefits or the institution of court proceedings.

Interpretation

Benefits under the Plan are provided on the condition that the Plan has the right to recover from responsible parties. The Claim Administrator, shall, in its sole discretion, determine how, when and the extent to which it will exercise the Plan's recovery rights.

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claim Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Assignment of Benefits

The Plan contains an anti-assignment provision. This provision provides that no benefit payable at any time under the Plan shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, provided that a Participant may assign benefits for medical care under this Plan to the provider of that care. None of the following shall be liable for, or subject to, any obligation or liability of any Participant (e.g., through garnishment, attachment, pledge or bankruptcy): the Plan, the Plan Administrator, the Claim Administrator or the Company. Benefits under the Medical Benefit Option of this Plan may not be assigned, transferred or in any way made over to another party by a Participant. Nothing contained in the written description of the Company's Medical Benefit Option shall be construed to make the Plan or the Company liable to any third-party to whom a Participant may be liable for medical care, treatment, or services.

COBRA Continuation Coverage

This section contains important information about COBRA continuation coverage, which is a temporary extension of coverage under the Plan for certain benefits, including medical, dental and vision coverage. This section generally explains COBRA continuation coverage, when it may become available and what you need to do to protect the right to receive it.

COBRA continuation coverage is a continuation of coverage under the Plan when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children, if applicable, could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage (plus a 2% administrative fee).

You will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happen:

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

Your spouse will become a qualified beneficiary if he or she loses his or her coverage under the Plan because any of the following qualifying events happen:

- you die;
- your hours of employment are reduced;
- your employment ends for any reason other than your gross misconduct;
- you become entitled to Medicare benefits (under Part A, Part B, or both); or
- you divorce or become legally separated from your spouse.

> **NOTE:** While entitlement to Medicare can be a COBRA qualifying event, when an actively-working employee becomes entitled to Medicare, *neither the employee nor the employee's covered family members will lose coverage under the Plan*. If such an employee voluntarily drops Plan coverage because of his or her entitlement to Medicare, this is not a COBRA qualifying event for the employee.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- you die;
- your hours of employment are reduced;
- your employment ends for any reason other than your gross misconduct;
- you become entitled to Medicare benefits (Part A, Part B, or both);
- you divorce or become legally separated; or
- the child reaches the limiting age for coverage as a dependent or otherwise stops being eligible for coverage under the Plan as a "dependent."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company and that bankruptcy results in the loss of coverage of any employee covered under the Plan, you will become a qualified beneficiary with respect to the bankruptcy.

When COBRA Coverage is Available

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its delegate with respect to the administration of COBRA (the "COBRA Administrator") has been notified that a qualifying event has occurred. When the qualifying

event is the end of employment, reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Company will notify the COBRA Administrator of the qualifying event.

> **NOTE:** Discovery Benefits is the COBRA Administrator for all benefit options. Discovery Benefits' contact information is set forth in the section entitled "General Information About the Plan."

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 Human Resources within 60 days after the qualifying event occurs. If you fail to provide timely notice, no COBRA continuation coverage will be available for an otherwise eligible dependent.

How COBRA Coverage is Provided

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. You will receive a notice from the COBRA Administrator (the "COBRA notice") that describes your COBRA rights, the cost of the available coverage option(s), and the time limits for electing continuation coverage and for paying the premium cost of coverage.

> **NOTE:** You must pay the full cost of COBRA continuation coverage, as determined by the Plan Administrator from time to time consistent with applicable IRS rules. The cost of COBRA coverage includes a 2% charge to cover administrative expenses.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses and/or dependent children.

> **NOTE:** You must pay the full cost of COBRA continuation coverage on a timely basis. The time limits for payment are described in the COBRA notice. COBRA continuation coverage, if you elect it, is retroactive to the date your active medical coverage is lost. Consequently, your COBRA premium payments are first applied to the cost of coverage for the period or periods immediately following the date your active medical coverage is lost. You cannot elect to pay only for COBRA continuation coverage for periods following the date of your election.

How Long COBRA Coverage May Last

COBRA coverage is a temporary continuation of coverage.

When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), a participant's divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage may generally last for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

NOTE: 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 fewer than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee may last until 36 months after the date of Medicare entitlement. For example, if a covered employee became entitled to Medicare eight months before the date on which his or her employment terminates, COBRA continuation coverage for his or her 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).

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 ("SSA") to be disabled and you notify Human Resources 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. To qualify for the extension, the SSA must have made its disability determination after you have elected COBRA continuation coverage, and the disability must last at least until the end of the 18-month period of continuation coverage. For the 29-month continuation coverage period to apply, your or your family member must inform the Company within 60 days of the date of disability determination and before the end of the original 18-month continuation coverage period. If, during continued coverage, the SSA determines that you or your family member is no longer disabled, you must inform the Company of this re-determination within 30 days of the date it is made.

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/or 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. This extension may be available to your spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or get divorced or legally separated, or if your dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

When You Acquire a Dependent during a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to your COBRA coverage under the Plan for the remainder of the continuation period if:

- He or she meets the Plan's definition of an eligible dependent,
- The Company is notified about your dependent within 30 days of eligibility, and
- Any additional contributions for continuation are paid on a timely basis.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months period described above (as applicable). Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended continuation period.

- You or your covered dependents do not pay required contributions. Coverage will end retroactive to the end of the last period for which contributions were timely paid.

- You or your covered dependents become covered, after the date COBRA coverage is elected, under another group plan that does not restrict coverage for preexisting conditions. If your new plan limits preexisting condition coverage, COBRA coverage under the Plan may remain in effect until the preexisting clause ceases to apply or the maximum COBRA continuation period is reached under this Plan.

- The date the Company no longer offers a group health plan.

- The date you or a covered dependent becomes enrolled, after the date COBRA coverage is elected, in Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.

- You or your dependent dies.

Questions About COBRA

You should contact the Benefits Department with questions concerning your COBRA continuation coverage rights. For more information about your rights under ERISA, including COBRA, the HIPAA, and other laws affecting group health plans, you should contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in his or her area or visit the EBSA Web site at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Website.

Participants Must Keep the Plan Informed of Address Changes

In order for you to protect your family's rights, you should timely keep the Plan Administrator informed of any changes in your address and the addresses of your spouse and dependent children. You should keep a copy, for your records, of any notices you send to the Plan Administrator.

Claims Procedures

To the extent that an option under the Plan is self-funded by the Company, the claims procedures described below will be the rules that apply for claims brought under that option. With respect to an option provided by means of insurance, you should refer to the insurance carrier's materials for more information about bringing claims under an insured option. If there are any inconsistencies between the information summarized below and the claims procedure utilized by the Claim Administrator with respect to your benefit option, the Claim Administrator's claims procedure will control. If you have any questions about bringing a claim under the Plan, contact the Benefits Department.

All claims for benefits are administered and determined by the Claim Administrator for the Plan option that covers you and your dependents. The Claim Administrator also makes all determinations with respect to the appeal of a denied claim. The Company plays no role in determining whether to pay, or not pay, any claim for benefits under the Plan.

NOTE: If your claim relates to your (or your family member's) eligibility to participate, or continue to participate, in the Plan (rather than a claim for benefits), you should file your claim with the Company as Plan Administrator (rather than with the Claim Administrator). The Plan Administrator will make its decision to accept or deny an eligibility-related claim within a reasonable time following its receipt of all information it determines it needs to render a decision. The Plan Administrator will communicate its decision to accept or deny an eligibility-related claim in writing to you, which will include, if the claim is denied, an explanation of the denial. The Plan Administrator's decision with respect to an eligibility-related claim shall be final and non-appealable.

Initial Claim Determination

You have the right for your eligible claim for a medical benefit to be paid in a timely manner. Such claim must be submitted for reimbursement within 90 days from the date of service. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you submit it as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

All claims must include the following information:

- The individual who has incurred the eligible charges
- The nature of the eligible charges
- The amount of the eligible charges and
- A statement that confirms the amount of charges that have been paid through insurance or from any other source.

If requested by the Claim Administrator, the claimant or the provider of the benefits must provide evidence to substantiate the nature, amount and timeliness of such charges.

NOTE: Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this section or the following sections "If Your Claim is Denied" and "External Review" includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

By law, a claim for benefits with respect to the Plan must be evaluated and processed within a time frame that depends on the nature of the claim. Different time frames may apply depending on whether a claim is urgent, pre-service (but not urgent), or post-service.

Urgent Care Claims

An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Claim Administrator or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 24 hours after the claim is received. If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not fewer than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Claim Administrator's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Claim Administrator's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a representative of the Claim Administrator responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to the Claim Administrator and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

If Your Claim is Denied

If all or part of a claim for benefits is denied, you will receive a written Explanation of Benefits (EOB) Statement or other claim denial notice. In an urgent situation, you may be notified verbally of a denial within the appropriate timeframe, with written confirmation sent within three days.

Any notice of benefit denial shall set forth:

- the specific reason or reasons for the denial, including reference to specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation why such material or information is necessary;
- a description of the applicable review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.
- if an internal rule, guideline, protocol or similar criterion was relied upon by the Claim Administrator in denying the claim, either the specific rule, guidelines, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied on making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- in the case of an adverse benefit determination by a Claim Administrator concerning a claim involving urgent care, a description of the expedited review process applicable to such claims; and

- such other information as may be required in accordance with regulations or guidance implementing changes to the claim and appeal process made by the Affordable Care Act (otherwise known as "health care reform").

Appealing a Denied Claim

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination from the Claim Administrator relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Coverage determinations, including plan limitations or exclusions;

- The results of any Utilization Review activities;

- A decision that the service or supply is experimental or investigational; or

- A decision that the service or supply is not medically necessary.

NOTE: If a benefit is denied because you or your dependent are determined to be not eligible for coverage (including any prospective or retroactive termination of coverage), you should appeal the denial to the Company as Plan Administrator, not the Claim Administrator. For further information, see "Claims Procedures," above.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Time Limits for Appeals

A request for review should be filed with the Claim Administrator.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to the Claim Administrator. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that the Claim Administrator provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial. For the Plan options for which AmeriBen is the Claim Administrator, you may call AmeriBen's member services unit at the toll-free phone number on the back of your ID card (also listed at the end of this booklet). Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and the Claim

Administrator by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If AmeriBen is your Claim Administrator and if you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with AmeriBen. You will be notified of the decision not later than 36 hours after the appeal is received. If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with AmeriBen within 60 days of receipt of the level one appeal decision. AmeriBen will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

Full and Fair Review of Claim Determinations and Appeals

Claims will be reviewed fully and fairly, taking into account the comments and information submitted by the claimant. The review will be conducted by one or more individuals who are not the same as, or who are subordinate to, the individuals who made the initial determination (or any prior determination on appeal, if a multi-level review process is available). The determination will be made independently, without reference to any prior determination(s) for the claim. Determinations will be made on a consistent basis in like circumstances, in accordance with the terms of the Plan and the Claim Administrator's applicable internal guidelines.

Where a determination requires medical judgment, the Claim Administrator will consult a healthcare professional with appropriate experience and training in the applicable field of medicine. This consultant will not be, or be subordinate to, any consultant previously involved with the initial claim decision (or any prior level of review on appeal, if applicable).

You are required to cooperate with the Claim Administrator and provide or allow it to obtain information relevant to its determination. You will be provided, free of charge, and be given a reasonable opportunity to review and respond to: (A) relevant new or additional evidence obtained by the Claim Administrator, which you have not had the opportunity to review; and (B) a relevant new or additional rationale for deciding the appeal, which you have not had the opportunity to address.

Urgent care claim appeals will be decided as soon as possible, but in all cases within 36 hours of submission.

Pre-service appeals that are not urgent will be decided within a reasonable period not to exceed 15 days. This period may be extended one time by the Claim Administrator for up to 15 additional days, provided the Claim Administrator both determines that the extension is necessary due to circumstances beyond its control and the Claim Administrator notifies you, prior to the expiration of the initial 15-day period, of the circumstances that require an extension and when a decision is expected to be rendered.

If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from receipt of the notice within which to provide the required information.

Post-service appeals will be decided within a reasonable period not to exceed 30 days. This period may be extended one time by the Claim Administrator for up to 15 additional days, provided the Claim Administrator both determines that the extension is necessary due to circumstances beyond its control and the Claim Administrator notifies you, prior to the expiration of the initial 30-day period, of the circumstances that require an extension and when a decision is expected to be rendered.

If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you

shall be afforded at least 45 days from receipt of the notice within which to provide the required information.

If your appeal is denied, in whole or in part, notice of determination will be provided to you in writing. Such written notice shall describe the option of an external review (or by appeal to an independent review organization as described below), and describe the procedures and time limits applicable for accessing such additional external level of review. Otherwise, all decisions on appeal shall be final and binding upon you, your dependents, and any other persons who claim an interest with respect to your claim for benefits in the Plan.

NOTE: The Claim Administrator for certain benefit options may offer a two-level internal review process for claim appeals.

In such event, if your claim appeal is denied, the Claim Administrator will advise you how to file a second level appeal, including the time limits for filing, how long the Claim Administrator will take to render its decision and whether such second-level appeal is mandatory before proceeding to external review.

Exhaustion of Internal Appeals Process

Generally, you are required to exhaust the Plan's internal claims appeal process before being able to obtain External Review (for the medical plan only) or bring an action in litigation. However, if the Claim Administrator, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA.

External Review

"External Review" is a review of an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from the Claim Administrator will describe the process to follow if you wish to pursue an External Review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to the Claim Administrator within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

Generally, the External Review process under the Plan gives you the opportunity to receive a review of an Adverse Benefit Determination that was based on "medical judgment" or was a rescission (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law and solely with respect to the self-insured medical benefit option under the Plan (excluding the health care Flexible Spending Account). Your request will be eligible for External Review if the following are satisfied:

- the Claim Administrator does not strictly adhere to all claim determination and appeal requirements under federal law; or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

NOTE: A claim denial based upon your eligibility to participate (including any prospective or retroactive termination of coverage) is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, AmeriBen and the Plan unless otherwise allowed by law.

Preliminary Review

Within 5 business days following the date of receipt of the request, the Claim Administrator must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review.

Within one business day after completion of the preliminary review, the Claim Administrator must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Claim Administrator must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO

The Claim Administrator will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, AmeriBen and the Plan. The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the

Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, the Claim Administrator and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

In the event that you have a claim for urgent care, you may request external review on an expedited basis. You may make this request after receiving any claim denial by the Claim Administrator, whether or not you have exhausted all appeal levels with the Claim Administrator. The procedures for expedited external review are generally the same as for other external reviews, except that determinations will be made (and notices will be provided) as soon as possible, and information will be transmitted in an expeditious manner to provide for a final external determination that is made as expeditiously as the circumstances require. In any event, the ERO will make its determination within 72 hours after the ERO receives the request for an expedited external review. Notice of the ERO's determination does not need to be provided in writing initially, but written notice confirming the determination must be provided within 48 hours of the initial verbal notice.

Immediately upon receipt of the request for expedited External Review, the Claim Administrator will determine whether the request meets the reviewability requirements. The Claim Administrator must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for External Review following preliminary review, Claim Administrator will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, the Claim Administrator and the Plan.

Amending or Terminating The Plan

Although the Company expects to continue the Plan, Sunoco GP LLC reserves the right to amend or terminate the Plan at any time and for any reason.

No Guarantee of Employment

Your eligibility or your right to benefits under the Plan should not be interpreted as a guarantee of employment. Participation in the Plan does not interfere with the Company's right to terminate your employment at any time.

No Guarantee of Tax Consequences

Although the Plan intends to offer most benefits on a tax-favored basis, there is no guarantee that any particular tax result will apply. The Company has the authority to take action necessary to prevent the Plan or any of the options from discriminating in favor of any employee or group of employees in a manner that would result in adverse tax consequences under the Plan, including the suspension of coverage or contributions of such employees.

Nothing in this Summary Plan Description constitutes tax advice. If you have any questions about the tax consequence of a benefit, you should consult your personal tax advisor.

Termination or Suspension of Benefits

The Plan Administrator may terminate or suspend your benefits for any of the following reasons: (1) failure to repay payments made in error; (2) unauthorized utilization (including failure to cooperate in the Plan's enforcement of its coordination of benefits rules or the protection of its subrogation/reimbursement rights); or (3) misrepresentation or fraud. In addition, the Company reserves the right, in its discretion, to take other measures in an appropriate case, up to and including termination of your employment.

Failure to Repay Payments Made in Error

You are obligated to repay amounts that the Plan has paid in error to you or your dependent, or on your or your dependent's behalf. Such repayment could include applying other eligible claim payments against any balance due. A "payment in error" includes, but is not limited to, overpayments due to an administrative error. If you do not repay the money or otherwise fail to cooperate with the Plan Administrator or Claim Administrator in its recoupment of monies owed, your and your dependent's benefits will be suspended until the money is repaid in full, or until the Company receives the initial repayment in accordance with the terms of a voluntary repayment plan agreed to between you and the Company. If you agree to a repayment plan and fail to make a timely payment under the repayment plan, your and your dependent's benefits will be terminated.

NOTE: Suspension of benefits in the event of a failure to repay is not a qualifying event for continuation coverage under COBRA.

Unauthorized Utilization

If you or your dependent obtain or receive benefits when not eligible for such benefits (e.g., loss of benefits due to divorce, loss of dependent coverage, etc.) or if you or your dependent fails to cooperate with respect to the Claim Administrator's administration of the Plan's coordination of benefits rules or the enforcement of the Plan's subrogation/reimbursement rights, you will be required to repay the Plan for the full amount paid by it. The repayment could include applying other eligible claim payments against any balance due. If you do not repay the money or otherwise fail to cooperate with the Plan Administrator or Claim Administrator in its recoupment of monies owed, or the protection of the Plan's subrogation/reimbursement rights, your and your dependent's benefits will be suspended until the money is repaid in full, or until the Company receives the initial repayment in accordance with the terms of a voluntary repayment agreed to between you and the Company. If you agree to a repayment plan and you should fail to make a timely payment under the repayment plan, your and your dependent's benefits will be terminated.

NOTE: Suspension of benefits in the event of the unauthorized utilization of benefits is not a qualifying event for continuation coverage under COBRA.

Misrepresentation or Fraud

Providing false or misleading information with respect to eligibility, benefits or any other aspect of the Plan will be considered fraud and an intentional misrepresentation of a material fact. If you obtain or receive benefits under the Plan as a result of false information or a misleading or fraudulent representation, your coverage will be suspended (possibly retroactively) and you must repay all amounts paid by the Plan. The repayment could include applying other eligible claim payments against any balance due. The suspension applies to your entire family. If you make full restitution, your coverage may, in the Plan Administrator's sole discretion, be restored. If your eligible dependent is responsible for such misrepresentation or fraud, all coverage for your dependent will be suspended immediately. If your dependent makes full restitution, his or her benefits may, in the Plan Administrator's discretion, be restored.

NOTE: Termination or suspension of benefits due to misrepresentation or fraud is not a qualifying event for continuation coverage under COBRA.

NOTE: You must notify the Benefits Department if your dependent no longer qualifies for Plan coverage. If the Plan pays for benefits of an individual who was covered under the Plan as your dependent when benefits are incurred after that individual ceases to be eligible for coverage, you will be required to repay the Plan the full amount of such benefits upon the demand of the Plan Administrator, unless alternative repayment arrangements are made with the Company. An example is in the case of a divorce. You must notify the Company immediately when the divorce is final. Your spouse's coverage will be terminated on the actual date of divorce. If you delay, you will be responsible for any claims incurred by your ex-spouse after the date of the divorce until the time the Company was notified and you will not be eligible for a refund of your contributions paid during the period of ineligibility.

Governing Law

This Plan shall be governed by and construed in accordance with ERISA and other applicable federal laws and, to the extent not superseded, the laws of the State of Texas.

Contact

If you have questions about the information provided in this Summary Plan Description, contact the Claim Administrator directly (contact information is set forth in the section entitled "General Information About the Plan.") or contact the Benefits Department at 713-989-2161.

Women's Health and Cancer Rights Act ("WHCRA")

WHCRA requires that group health plans, such as the Plan, that provide coverage for medically necessary mastectomies to also provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Appropriate prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedemas

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Claim Administrator.

Newborn and Mothers Healthcare Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to fewer than 48 hours following a vaginal delivery, or fewer than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceeds 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Mental Health Parity

Plans that offer both medical and surgical benefits and mental health or substance abuse benefits must ensure that the financial requirements that apply to the mental health or substance abuse benefits are no more restrictive than the most common or frequent financial requirements that apply to substantially all medical and surgical benefits covered under the plan. "Financial requirements" include deductibles, co-payments, co-insurance and out-of-pocket expenses. If you have any questions regarding the mental health parity rules and how they may apply to you or your dependents, contact the Claim Administrator.

Nondiscrimination

The law prohibits the Plan from discriminating against you on the basis of several factors including age, gender, race, and genetic information. The Plan will comply with all applicable nondiscrimination laws.

Confidentiality of Your Information

In addition to the requirements under HIPAA, the Company is committed to protecting the privacy of your and your dependents' personal information. the Company has procedures in place that will take appropriate measures to keep such information confidential. A copy of the Plan's HIPAA Notice of Privacy Practices can be obtained from the Benefits Department.

Your ERISA Rights

The Employee Retirement Income Security Act of 1974, known as ERISA, guarantees your rights as a Plan participant. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. At your request additional copies of the annual financial report may be provided, but the Plan Administrator may charge a reasonable fee for the copies.

Continue Group Health Plan Coverage & HIPAA Certificates of Creditable Coverage

- Continue health care coverage for yourself, spouse and/or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurer issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan.

Prudent Action by Plan 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 and other Plan participants and beneficiaries.

No one, including the Company or any other person, may take any action 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 Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

General Information about the Plan

Name of Plan: Sunoco GP LLC Health and Welfare Program for Active Employees

Type of Plan: Welfare Benefit Plan

Plan Number: 519

Plan Year: January 1 – December 31.

Plan Effective Date: January 1, 2015 (amended and restated)

Plan Sponsor and Named Fiduciary:

Sunoco GP LLC
c/o Benefits Department
1300 Main Street
Houston, TX 77002
713-989-2161
Employer Identification Number (EIN): 23-1743283

Plan Administrator:

Sunoco GP
c/o Benefits Department
1300 Main Street
Houston, TX 77002
713-989-2161

COBRA Administrator:

Discovery Benefits

PO Box 2079
Omaha, NE 68103-2079
877-765-8810

Agent for Service of Legal Process:

Sunoco GP LLC c/o Corporation Service Company
2711 Centerville Road, Suite 400
Wilmington, DE 19808

Service for legal process may also be made on the Company, as Plan Administrator.

Type of Administration:

The Sunoco GP LLC Health and Welfare Program for Active Employees is administered under the terms of administrative services contracts or insurance contracts between the Company and a variety of third-party administrators and insurance carriers. These third-party administrators and insurance carriers as shown in the table below. The materials provided by the third-party administrators and insurers, together with the Sunoco GP LLC Health and Welfare Program for Active Employees, make up the official plan document as required by ERISA. The official Plan documents, which include the insurance contracts and/or certificates of coverage and Claims Administration Documents, prevail in case of any conflict.

The following is a list of the available Plan benefit options as of the date of this SPD. The Company may add or discontinue benefit options at any time.

Type of Welfare Benefits	Eligibility	Type of Plan Administration	Insurer or Claim Administrator
Medical Benefits	Full-Time Employees & Part-Time Employees	*For Non-Aloha Employees:* Self-Funded and Contract Administered (Benefits are provided from the general assets of the Company and claims are administered by a third party.) *For Aloha Employees:* Insured	*For Non-Aloha Employees:* AmeriBen P.O. Box 7186 Boise, ID 83707 866-215-0976 *For Aloha Employees:* HMSA PO Box 860 Honolulu, HI 96808 www.hmsa.com 808-871-6295
Medical Benefits	Full-Time Employees & Part-Time Employees	Self-Funded and Contract Administered	Caremark/CVS www.caremark.com 800-837-4092
Vision Benefits	Full-Time Employees & Part-Time Employees	Self-Funded and Contract Administered	*For Non-Aloha Employees:* Vision Service Plan (VSP) PO Box385018 Birmingham, AL 35238 www.vsp.com 800-877-7195 *For Aloha Employees:* Blue Cross Blue Shield of Hawaii PO Box 860 Honolulu, HI 96808 www.hmsa.com 808-871-6295

Type of Welfare Benefits	Eligibility	Type of Plan Administration	Insurer or Claim Administrator
Dental Benefits	Full-Time Employees & Part-Time Employees	Self-Funded and Contract Administered	Delta Dental Insurance Company of Texas 1130 Sanctuary Pkwy Suite 600 Alpharetta, GA 30009 www.deltadentalins.com 800-521-2651
Life and AD&D Benefits	Full-Time Employees	Insured	Hartford PO Box 2999 Hartford, CT 06104 www.thehartford.com 800-303-9744
Long-Term Disability	Full-Time Employees ***Note: This option is only available to Retail Store Employees classified as Managers or Managers-in-Training. In addition, Eligible Employees who are classified as temporary employees are not eligible to participate in this benefit.***	Insured	Hartford PO Box 2999 Hartford, CT 06104 www.thehartford.com 800-303-9744
Employee Assistance Plan	Full-Time Employees	Insured	ComPsych Corporation www.guidanceresources.com 800-327-1850

Participating Affiliates:

The following entities are Participating Affiliates in the Plan:

- Aloha Petroleum, Ltd. (EIN: 99-0170854)
- Applied Petroleum Technologies, Ltd. (EIN: 74-2739958)
- GoPetro Transport LLC (EIN: 26-1583414)
- Stripes LLC (EIN: 74-2737572)
- Sunoco, GP, LLC (EIN: 90-0857728)
- Sunoco, Inc. (R&M) (EIN: 23-1743283)
- Sunoco Energy Services LLC (EIN: 75-1476269)
- Sunoco LLC (EIN: 46-4151222)
- Susser Petroleum Company LLC (EIN: 74-2908184)