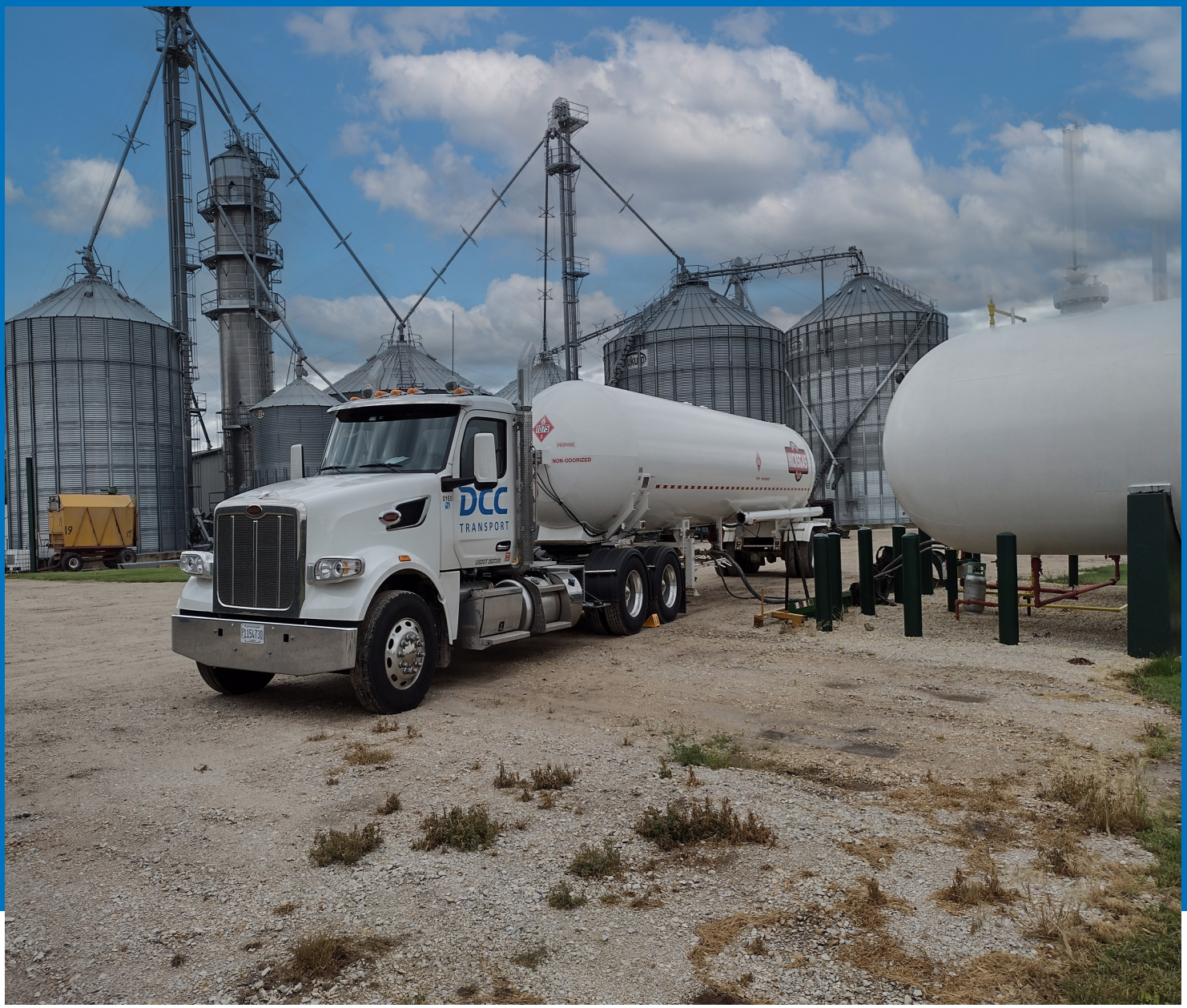
DCC Propane Benefit Summary



DCC PROPANE, LLC

2025

Welcome!

DCC Propane is excited to provide you with an overview of our 2025 health and welfare benefit options available to you and your dependents. Here at DCC Propane, we take the health, safety, and overall well-being of our employees very seriously and want to ensure that our benefits options are reflective of that. Benefits are an important part of your overall compensation package with DCC Propane. These benefits are provided to help protect and support you and your loved ones through daily living, as well as unexpected life events. This guide was developed to provide critical information about our benefits programs, so that you can choose the best plan for both you and your family.

Partners in Value

At DCC Propane, we do all we can to mitigate the effect of rising healthcare costs. We look at the design of our benefit programs, the providers we work with and the role you can play in maintaining the affordability of our plans. We are asking you to partner with us to control costs by learning about the coverage available to you and how to use it most effectively. DCC Propane provides you with a number of tools and resources, but it's up to you to stay informed, make the right choices and then make the most of the benefits you have. Choose well, use well and be well!

When Coverage Begins

New Hires

Your insurance elections become effective on the 1st of the month following the completion of 30 days of employment. If you forget, miss, or fail to enroll in benefits, you will not be covered under any employee-elected benefit plans and you will need to wait until the next open enrollment period or Qualified Life Event.

Annual Open Enrollment

All benefit changes and/or new elections selected during open enrollment will go into effect as of January 1st.

Changes after Enrollment

Be mindful and consider all your options under the DCC plans or alternate plans that may be available to you and your family before you select your benefits. Open enrollment through DCC would often be considered a qualifying event under a spouse's benefit plan. Ensure you review the total amount of any employee premiums for benefits you are selecting to ensure those choices are right for your family. In the event you need to make a change or want to cancel coverage after enrollment, it can only be done during annual open enrollment or if you have a qualifying life event. **Here are some of the common examples that the IRS states qualify as a Qualified Life Event.**

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse, Registered Domestic Partner, or child
- You lose coverage under your spouse's/registered domestic partner's plan
- You gain access to state coverage under Medicaid or CHIP

Should you have one of these events, you must contact human resources within 31 days of the event and have any supporting documentation available.

If you have questions on when and how to enroll, please reach out to a member of the Human Resources Team.

DCC Propane, LLC reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. Notice of any changes to the Plan, or a termination of the Plan, will be issued to participants and their beneficiaries within a reasonable amount of time prior to the change's implementation.

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Eligibility

If you are a regular, full-time employee, you are eligible for the below benefit plans. You will be automatically enrolled in the Basic Life Insurance, Accidental Death and Dismemberment Insurance, Short-term and Long-term Disability.

Benefit Plan Coverage	Coverage Begins	Coverage Ends
Medical & Prescription Drug	1st day of the month following the 30th day of employment	Last Day of the Month
Spending Accounts	1st day of the month following the 30th day of employment	N/A
Dental	1st day of the month following the 30th day of employment	Last Day of the Month
Vision	1st day of the month following the 30th day of employment	Last Day of the Month
Basic Life	1st day of the month following the 30th day of employment	Last Day of the Month
Basic Accidental Death and Dismemberment	1st day of the month following the 30th day of employment	Last Day of the Month
Voluntary Life	1st day of the month following the 30th day of employment	Last Day of the Month
Voluntary Accidental Death and Dismemberment	1st day of the month following the 30th day of employment	Last Day of the Month
Short Term Disability	1st day of the month following the 30th day of employment	Immediately
Long Term Disability	1st day of the month following the 30th day of employment	Immediately
Voluntary Accident, Critical Illness, and Hospital Indemnity	1st day of the month following the 30th day of employment	Last Day of the Month

Enrollment Guidelines

Whether you are enrolling for the first time as a new hire, or during annual enrollment - whatever you elect at that time will be what you will have for the remainder of the plan year. The next annual enrollment will be effective January 1, 2025.

Benefits elected during annual enrollment will remain in effect from January 1 to December 31. During each annual enrollment period, you will have the opportunity to review your benefit elections and make changes for the coming year. You are responsible for reviewing your paystub(s) within 30 days of receiving benefits to ensure that the correct deductions are being taken from your pay, and for notifying the HR department immediately if you believe a correction needs to be made.

Frequently Asked Questions	
Who is an eligible dependent?	-Your legal spouse -Natural, foster, step, and adopted children up to the age of 26 -Children of any age who are mentally and/or physically disabled and incapable of self sustaining employment, that depend chiefly on you for support -Your child covered by a QMCSO, meaning your child(ren) on whose behalf a Qualified Medical Child Support Order (QMCSO) has been entered or issued, indicating that coverage must be provided by you until the child covered by the QMCSO is no longer so covered or turns 26 years of age, whichever occurs first -Other Eligible Dependent, meaning a person who is not your child or the child of your spouse to whom you are related; for whom you have been appointed legal guardian; who is your dependent for federal income tax purposes.

Medical Insurance

Medical Insurance | BlueCross BlueShield

High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

This medical plan option is comprised of two components (1) a High Deductible Health Plan (HDHP) and (2) a tax-exempt savings account called a Health Savings Account (HSA).

The HDHP is a high deductible PPO plan that provides health care benefits after the deductible has been met. All medical services, with the exception of preventive care, are paid for by you at 100%, less carrier discounts, prior to meeting your entire annual deductible. This includes routine office visits, procedures, lab work, prescription drugs, etc.

The HSA is a bank account paired with your HDHP allowing you to set aside money on a tax-free basis to pay your out-of-pocket qualified medical, dental, and vision expenses throughout the year or in the future. You own the money in your HSA account and it is yours to keep – even when you change plans or retire. The funds roll over from year to year to be used when you really need them.

Choice of plan options:	$2,000 HDHP with HSA		$3,500 HDHP with HSA		$5000 HDHP with HSA	
Network	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Deductible Individual Family	Non-Embedded $2,000 $3,750	Non-Embedded $5,500 $10,750	Embedded $3,500 $7,000	Embedded $7,000 $14,000	Embedded $5,000 $10,000	Embedded $10,000 $20,000
Coinsurance	80%	60%	80%	50%	100%	70%
Out-of-Pocket Max Individual Family	$4,750 $9,250	$13,750 $27,250	$5,000 $10,000	$10,000 $20,000	$5,000 $10,000	$10,000 $20,000
Physician Services Well Adult / Child (no deductible) Physician Office / Specialist Visit X-Rays / Lab Diagnostics	100% 80% after ded 80% after ded	50% 60% after ded 60% after ded	100% 80% after ded 80% after ded	50% 50% after ded 50% after ded	100% 100% after ded 100% after ded	70% 70% after ded 70% after ded
Emergency Room	80% after ded	80% after ded	80% after ded	80% after ded	100% after ded	100% after ded
Inpatient Hospital stay	80% after ded	60% after ded	80% after ded	50% after ded	100% after ded	70% after ded
Outpatient Services	80% after ded	60% after ded	80% after ded	50% after ded	100% after ded	70% after ded
Urgent Care	80% after ded	60% after ded	80% after ded	50% after ded	100% after ded	70% after ded
Prescription Drugs Retail: Generic / Formulary / Non-Formulary / Specialty	80% after deductible / $0 copay preventative	80% (you are responsible for 25% of the eligible amount after coinsurance and deductible; Specialty not covered)	80% after deductible / $0 copay preventative	50% after deductible	100% after deductible / $0 copay preventative	100% after deductible
Prescription Drugs Mail: In-Network/ (Out-of-Network) Generic / Formulary / Non-Formulary / Specialty	80% after deductible	Not Covered	80% after deductible; Specialty: Not covered	Not Covered	100% after deductible	100% after deductible; (participating pharmacies) Specialty not covered

Blue Cross and Blue Shield of Illinois (BCBSIL) administers the preventive drug benefit for your group's high deductible health plan ("HDHP"), which has been designed for use with Health Savings Accounts ("HSAs"). The preventive drug benefit program includes categories of prescription drugs that are often used for preventive purposes. If your doctor has prescribed any of them to you or to your HDHP-covered dependents for preventive purposes, your HDHP may pay for the drugs at a reduced or $0 copay before you meet your HDHP deductible. *See Preventative Drug Program List for more details.*

Medical Rates - Wellness

High Deductible PPO $2,000		
Enrollment Tier	**Monthly**	**Biweekly**
Employee Only	$254.74	$117.57
Employee & Spouse	$534.95	$246.90
Employee & Child(ren)	$484.01	$223.39
Family	$764.22	$352.72
High Deductible PPO $3,500		
Enrollment Tier	**Monthly**	**Biweekly**
Employee Only	$179.19	$82.70
Employee & Spouse	$376.29	$173.67
Employee & Child(ren)	$340.45	$157.13
Family	$537.56	$248.10
High Deductible PPO $5,000		
Enrollment Tier	**Monthly**	**Biweekly**
Employee Only	$0.00	$0.00
Employee & Spouse	$245.64	$113.37
Employee & Child(ren)	$222.25	$102.58
Family	$350.92	$161.96

Beginning in 2025 there will be a $100 surcharge on ALL of the plans for those not actively participating in the EmPower Wellness program by May 31, 2025. To be considered active, you must be enrolled and have submitted either the doctor affidavit for a doctor visit from August 1, 2024 to May 31, 2025, or have completed the FREE biometric exam through the EmPower Wellness/Wellright Program.

Medical BCBS Contact Information	
Website	www.bcbsil.com
Phone Number	1-877-301-4392

Medical Insurance | BlueCross BlueShield

High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

This medical plan option is comprised of two components (1) a High Deductible Health Plan (HDHP) and (2) a tax-exempt savings account called a Health Savings Account (HSA).

The HDHP is a high deductible PPO plan that provides health care benefits after the deductible has been met. All medical services, with the exception of preventive care, are paid for by you at 100%, less carrier discounts, prior to meeting your entire annual deductible. This includes routine office visits, procedures, lab work, prescription drugs, etc.

Although you have the flexibility to see any doctor or visit any hospital of your choice, you will pay significantly less money out of your pocket if you use a doctor or hospital that is in the network. Preventive care services are covered at 100% as long as your physician codes your visit as preventive and services fall under the allowable preventive services guidelines (www.healthcare.gov/coverage/preventive-care-benefits). For other services, including routine office visits, procedures, lab work, prescription drugs, etc., no benefits will be paid until your annual deductible has been met.

The HSA is a bank account paired with your HDHP allowing you to set aside money on a tax-free basis to pay your out-of-pocket qualified medical, dental, and vision expenses throughout the year or in the future. The account can be funded with tax-exempt dollars by you, your employer or by anyone else on your behalf. You own the money in your HSA account and it is yours to keep – even when you change plans or retire. The funds roll over from year to year to be used when you really need them.

You're eligible for a health savings account if:

- You are covered by a qualified high deductible health plan (HDHP)
- You are not covered by any other medical coverage that is not considered a qualified HDHP
- You are not enrolled in Medicare (Part A included)
- You are not claimed as a dependent on someone's tax return
- You are not enrolled in a Medical Flexible Spending Account (your own or your spouse's)

Paying the true cost of your medical services, less carrier discounts, until your deductible has been met will feel a bit different than other medical plans you may have been enrolled in previously. The company will be making a contribution into your HSA on your behalf to help you pay towards any qualified medical expenses you may incur throughout the year. You too can put your own pre-tax dollars into this account for future medical expenses.

Your HSA plan banking is administered through HSABank. You may contact HSABank member services at 866-471-5275with questions about your account. To learn more about your HSA, please visit www.hsabank.com and register to manage your HSA online.

For 2025, here is what you can expect:

Tax-free Annual Contribution	Employee Only	Family
2025 Company Contribution $2,000 Plan	$250	$500
2025 Company Contribution $3,500 & $5,000 Plans	$500	$1,000

2025 IRS Maximum Contribution	Employee Only	Family
Maximum HSA Contribution	$4,300	$8,550
Catch-up Contribution (Age 55 and Older)	$1,000*	

*After age 65, the money can be withdrawn penalty free. However, you continue to be taxed on funds not used for qualified medical services. The tax-preferred status of your HSA contributions depend on a number of factors. For example, you must be enrolled in a qualified high deductible health plan. Also, residents of California and New Jersey are taxed on HSA contributions at the state level. State tax laws can change periodically, so you should consult with a tax advisor to confirm the tax treatment of HSA contributions in your state.

Advantages to having an HSA

- There's a triple tax savings benefit as contributions are not taxed going into the account, while they sit there earning interest or when they're taken out for a qualified medical expense
- You pay less in premium for this plan
- Unused funds rollover each year with no maximum on how much you can save and accumulate over time
- The account is portable so you never have to worry about losing the money in the account should you change between plans, retire or even seek employment elsewhere
- Your HSA can be viewed as a second means of savings for your retirement
- You control your healthcare spending and choose when to use your HSA dollars and when to save them
- You become a more informed participant in your healthcare and healthcare spending

Steps to using your HSA

1. Go to the doctor and present your carrier ID card
2. Your doctor submits your medical services to the carrier to be discounted
3. Your carrier adjusts the pricing to reflect the network discounted amount for your services
4. The carrier generates an Explanation of Benefits (EOB) and sends it to you
5. By now you've received an invoice from your doctor - make sure the EOB and invoice match
6. Pay your doctor directly with pre-tax dollars from your HSA or post-tax dollars from your pocket if funds are not available

Using your HSA on qualified expenses

You can use the money in your HSA to pay for qualified medical, dental and vision expenses permitted under federal tax law. Examples include, but are not limited to:

Medical Expenses

- Acupuncture
- Chiropractic care
- Fertility treatments
- Diagnostic services
- And more

Dental Expenses

- Crowns
- Dentures
- Orthodontia
- Teeth cleanings
- And more

Vision Expenses

- Vision exams
- Contacts
- Eye glasses
- Laser eye surgery
- And more

For a full list of qualified medical expenses go to www.irs.gov and search Section 213d.

BlueCross BlueShield Value Added Benefits

Value Added Benefits are in place to help an employee get the most for their benefit dollars.

BlueAccess for Members: www.bcbsil.com
A secure member website that gives you immediate access to health care benefit information. Here you can check claim status, find in-network providers, use the hospital comparison tool, and much more.

BlueAccess Mobile™
Access your BlueAccess for Members account from a mobile device. Opt in to receive texts for Rx refill reminders, diet and fitness tips, claim updates and more. Download the app for immediate access.

Virtual Visits—MDLIVE
MDLIVE's telehealth program provides enrolled members with access to non-emergency medical care, as well as behavioral health care, without even leaving the couch. Visit a doctor virtually 24 hours a day, 7 days a week for a variety of different ailments, symptoms, and concerns. Log on to MDLIVE.com/bcbsil or call 888.676.4204 today to find out additional info on this awesome benefit.

24/7 Nurseline: 800.299.0274 (HDHP Members)
General health info and guidance for specific conditions from fevers to bee stings from a registered nurse.

Maternity Care Program: 888.421.7781
Personalized support provided by Obstetrical nurses.

Mail Order Prescriptions: 800.423.1973
Through BCBS and Express Scripts, mail order prescriptions may save time and money.

Blue365 Discounts
Access to additional special program discounts. Details can be accessed by logging into Blue Access for Members via www.bcbsil.com. Once logged in, go to the *My Coverage* tab and click on *Discounts* found under *Member Advantages*.

Well onTarget Member Wellness Program
Access health and wellness resources that can help you manage your health. Resources include health assessments, self-directed courses and health coaching.

Tips to Save Money

Preventive/Wellness Exams Covered at 100%
- Preventive care is equal to one physical exam per year per enrolled member
- Females get an annual well-woman exam covered at 100% in addition to their annual physical exam
- No out-of-pocket costs apply - these exams are fully covered as long as your physician codes them as preventive

Prescription Drugs
- Ask your doctor if there's a generic version of any medication you're currently taking or being prescribed
- Take advantage of the Prescription Savings Programs at major retailers
- Ask about free samples from your doctor and/or manufacturer rebates
- **CVS is excluded from BCBSIL pharmacy network**

High Cost Scans, X-Rays & Tests
- MRI, PET scans, CT scans, etc. are nearly 2/3 less costly at free-standing, in-network imaging centers than at hospitals
- Whenever possible, compare cost options prior to scheduling your necessary services

Accessing Medical Care
The ER is a costly experience for issues that aren't true emergencies. There are alternatives that can offer quick care at a much more affordable cost. The key is finding these alternatives today when you're happy and healthy.
- Doctor's office: for symptoms that aren't life threatening, call and let them know your symptoms require immediate attention
- Convenient Care Clinics: use when you don't have a primary doctor or can't get an appointment. Good for fever, sore throat/strep, coughs/congestion, sports physicals, UTIs, etc.
- Urgent Care (UC): less costly than the ER; can treat sprains/strains, minor breaks, mild asthma, minor infections, rashes, small cuts, burns, etc.

Tips to Save Money (continued)

Benefit Value Advisor

The Benefit Value Advisor (BVA) program has been established to assist you in maximizing your benefits. Benefit Value Advisors are trained customer service representatives who assist you by comparing cost and providing information on Participating Providers for certain types of health care services. A BVA helps you navigate your benefits.

To reach a Benefit Value Advisor (BVA) call the customer service number on the back of your ID Card (800-458-6024).

Engagement Requirements

To satisfy the engagement requirements for services listed below, you must engage with a BVA via one of these methods: Connect with a BVA by calling the customer service number shown on the back of the identification card or use the Blue Access for Members (BAM) Provider Finder Tool online or through the mobile application to search for information about your Participating Provider options and estimated costs. If you have any questions about the engagement requirements you should connect with a BVA by calling (800-458-6024).

Engagement Requirements require members to speak to a BVA representative **WITHIN 60 DAYS PRIOR** to receiving DIAGNOSTIC IMAGING services or you will be charged **$100 penalty** with the processing of your claim! DCC has elected to have engagement requirements for the following:

- MRI and CT Scans
- Bariatric Surgery
- Diagnostic radiology
- Joint Replacement
- Musculoskeletal (inpatient)
- Musculoskeletal (outpatient)
- Reduction Mammoplasty

YOUR PLAN REQUIRES YOU TO CALL THE BVA NUMBER ON THE BACK OF YOUR BCBSIL CARD (800-458-6024) FOR A CONSULTATION WITHIN 60 DAYS PRIOR TO GETTING AN MRI OR CT SCAN (OR OTHER SERVICES LISTED ABOVE). IF YOU DON'T CALL BVA PRIOR TO ONE OF THESE SERVICES YOU WILL BE CHARGED A $100 PENALTY WITH THE PROCESSING OF YOUR CLAIM!

Dental Insurance

Dental Insurance | Delta Dental

Preferred Provider Organization (PPO)
These dental plans allow the flexibility to select any dentist in-network or out-of-network. By staying in-network, the contract between your dentist and insurance carrier will make your annual benefit period maximum last longer.

Dental coverage focuses on preventive and diagnostic procedures in an effort to avoid more expensive services associated with dental disease and surgery. The type of service or procedure received determines the amount of coverage for each visit. Each type of service fits into a class of services according to complexity and cost.

Preventive:
- Annual cleanings (2 per year)
- X-rays (1 per year)
- And more

Basic:
- Fillings
- Simple extractions
- And more

Major:
- Root canals
- Dentures/bridges/partials
- Crowns
- And more

Dental Plan

Choice of plan options:	*PPO In-Network (Highest Discount)*	*Premier In-Network (Moderate Discount)*	*Out of Network (No Discount)*
Individual Deductible	$50	$50	$50
Family Deductible	$150	$150	$150
Office Visit Copay	None	None	None
Preventive Coinsurance	100%	100%	100%
Basic Coinsurance	80%	80%	80%
Major Coinsurance	50%	50%	50%
Annual Plan Maximum	$2,000	$2,000	$2,000
Orthodontia Coinsurance	50%	50%	50%
Orthodontia Lifetime Maximum *Dependent children to age 19* *Adults eligible for coverage*	$1500	$1500	$1500

Dental Plan Rates

Enrollment Tier	**Monthly**	**Biweekly**
Employee Only	$15.50	$7.15
Employee & Spouse	$30.00	$13.85
Employee & Child(ren)	$33.00	$15.23
Family	$46.00	$21.23

Dental Insurance | Delta Dental

Delta Dental Enhanced Benefit Program

Delta Dental of Illinois' Enhanced Benefits Program integrates medical and dental care—where oral health meets overall health. This program enhances coverage for individuals who have specific health conditions that can be positively affected by additional oral health care. These enhancements are based on scientific evidence that shows treating and preventing oral disease in these situations can improve overall health. Our Enhanced Benefits Program includes additional cleanings and/or applications of topical fluoride. The costs of the additional cleanings and fluoride treatments will be applied to enrollees' annual maximums.

People Eligible	Treatment	Coverage Level	Frequency per Benefit Year
Individuals with: **Diabetes Kidney Failure/Dialysis Treatment** **High-Risk Cardiac Conditions***	Prophylaxis (General cleaning) & Periodontal Maintenance	Same percentage as the group contracted benefit level	4 times total in any combination
Individuals with: **Periodontal Disease** **Suppressed Immune Systems**** **Cancer-Related Chemotherapy and/or** **Radiation Treatments**	Prophylaxis (General cleaning) & Periodontal Maintenance Topical Fluoride Treatment (no age limits)	Same percentage as the group contracted benefit level Same percentage as the group contracted benefit level	4 times total in any combination Frequency determined by group contract
Pregnant Women	Prophylaxis (General cleaning) & Periodontal Maintenance	Same percentage as the group contracted benefit level	3 times total in any combination

**Includes the following conditions: a history of ineffective endocarditis; certain congenital heart defects; individuals with artificial heart valves; defects caused by acquired conditions like rheumatic heart disease; hypertrophic cardiomyopathy, which causes abnormal thickening of the heart muscle; individuals with pulmonary shunts or conduits; mitral valve prolapsed with regurgitation (blood leakage).*

***Includes the following conditions: HIV positive, organ transplant, stem cell (bone marrow) transplant.*

****The Oral CDx brush biopsy is standardly covered under oral surgery in Delta Dental of Illinois' benefit plan designs.*

Dental Contact Information	
Website	www.deltadentalil.com
Phone Number	1-800-323-1743
Network	PPO Plus Premier
Policy Number	20533

Vision Insurance

Vision Insurance | Vision Service Plan (VSP)

Vision insurance helps offset the costs of routine eye exams and also helps pay for vision correction eye wear, like eyeglasses and contacts, that may be prescribed by an eye-care provider.

By accessing in-network vision providers, you're able to reap the benefit of true vision insurance coverage. You're eligible for an eye exam, lenses or contact lenses, and frames, once per calendar year. Out-of-network providers will merely offer you an allowance towards your vision services.

Eye-care providers include many independent optical shops and national chains.

Vision Plan Details:	Frequency	In-Network	Out-of-Network
Network	VSP Advantage		
Eye Exam	Once per calendar year	$10 copayment	$45 allowance
Lenses - Single vision - Bifocal - Trifocal - Lenticular	Once per calendar year	$25 copayment	$30 allowance $50 allowance $60 allowance $75 allowance
Frames	Once per calendar year	$0 copay; 20% off balance over $150 allowance	$50 allowance
Necessary Contacts	Once per calendar year	100% after $10 copay	$210 allowance
Elective Contacts	Once per calendar year	$150 allowance	$100 allowance

*Vision benefit frequencies are based on the date of service within the policy year
** You cannot get contacts and glasses in the same calendar year

VSP has a series of perks to be aware of for being an enrolled member on the plan:
Extra 20% Savings - Maximize your benefits with an extra 20% off on top of your allowance, on any frame from a wide selection of featured frame brands. Simply select a featured frame brand in any VSP doctor's office and the 20% will automatically be applied to your purchase.

TruHearing - As a VSP member, savings on digital hearing aids and replacement batteries for you and your extended family through TruHearing* are available.
*Check your benefits to see if this offer applies

Enrollment Tier	Monthly	Biweekly
Employee Only	$4.24	$1.96
Employee & Spouse	$8.48	$3.91
Employee & Child(ren)	$9.07	$4.19
Family	$14.49	$6.69

Vision Contact Information	
Website	www.vsp.com
Phone Number	1-800-877-7195
Network	VSP Advantage

Additional Benefits

Basic Life and AD&D Insurance | New York Life

Basic Life Insurance helps ease your loved ones' financial burden. Your designated beneficiary will receive a benefit if you pass away from a covered accident or illness. In addition, Accidental Death and Dismemberment (AD&D) provides a benefit to your beneficiary if you pass on or become dismembered due to a specifically covered accident. Always make sure your beneficiaries are updated. **The cost of the benefit is 100% paid for by the company.**

	Basic Life/Accidental Death & Dismemberment
Benefit Amount	2x Salary up to $500,000

Short & Long-Term Disability | New York Life

If you become ill or suffer an injury that prevents you from working, this form of disability insurance replaces a portion of your income for a defined maximum period of time.

Disability Coverage	Short-Term	Long-Term
Waiting Period	Begins on the 1st day of accident and 8th day of illness	Begins on the 91st day of continuous injury or illness
Benefit Amount	60% of weekly earnings	60% of monthly earnings
Maximum Benefit	$1,500 per week	$10,000 per month
Length of Payment Period	13 weeks	SSNRA
Premium Contribution	**Company paid**	**Company paid**

Voluntary Term Life and AD&D Insurance | New York Life

Voluntary Term Life/AD&D allows you to purchase additional coverage at your own financial expense to ease your loved ones' financial burden if something should happen to you. Costs are determined on group discounted rates. Always make sure your beneficiary information is updated.

The cost of the benefit is 100% paid for by you. Your age and the amount of insurance you elect determines the premium you'll pay. Costs will go up as you age. See your plan documents for more detail.

	Employee	Spouse	Child(ren)
Coverage Increments	$10,000	$5,000	$1,000
Maximum Benefit Amount	$500,000	$500,000	$10,000
Guaranteed Issue Amount*	$200,000	$50,000	$10,000

Contact Information	
Website	www.newyorklife.com/group-benefit-solutions/forms
Phone Number	1-888-842-4462

Voluntary Products | New York Life

Accident Insurance | New York Life
This coverage can pay a specific dollar amount for off-the-job accidents. If you suffer a covered injury, the plan pays cash benefits that you can use to help with hospital deductibles, doctor visits, emergency room care, and physical therapy.

Enrollment Tier	Monthly	Biweekly
Employee Only	$6.47	$2.99
Employee & Spouse	$10.99	$5.07
Employee & Child(ren)	$15.68	$7.24
Family	$23.05	$10.64

Hospital Indemnity | New York Life
This coverage pays a cash benefit if you or an insured dependent (spouse or child) are confined in a hospital for a covered illness or injury. The benefits are paid to you in a lump sum, and can help offset your primary health insurance expenses like your deductible and coinsurance payments—or it can be used for non-medical expenses like housing costs, groceries, car expenses, and more!

Enrollment Tier	Monthly	Biweekly
Employee Only	$15.25	$7.04
Employee & Spouse	$36.83	$17.00
Employee & Child(ren)	$25.64	$11.83
Family	$49.75	$22.96

Critical Illness | New York Life
This coverage is designed to help you offset the costs of certain covered critical illnesses. If diagnosed, you will receive a lump-sum cash benefit that you can use for any medical expense, or any day-to-day costs of living expenses like your mortgage or utility bills. Some covered conditions are full benefit cancer, severe burns, heart attack, stroke, coma, Alzheimer's Disease, major organ transplant benefit. See benefit guide for full listing.

Eligible Individual	Initial Benefit
Employee	Increments of $5,000 up to $30,000
Spouse	100% of employee's benefit
Dependent Child(ren)	50% of employee's benefit

The cost of these voluntary benefits are 100% paid for by you.

Contact Information	
Website	www.newyorklife.com/group-benefit-solutions/forms
Phone Number	1-888-842-4462

Employee Assistance Program (EAP) | NY Life

Life: just when you think you've got it figured out, along comes a challenge. Whether your needs are big or small, New York Life Group Benefit Solutions is there for you with our Employee Assistance & Wellness Support program. It can help you and your family find solutions and restore your peace of mind. This is just another example of how we are committed to Putting Benefits to Work For People.

Possible reasons to call can include:

- Stress and depression
- Life transitions
- Grief and loss
- Parenting and child care
- Elder care referrals
- Domestic violence
- Workplace conflict
- Work/life balance
- Addiction and recovery
- Financial issues
- Legal assistance
- And more

The Employee Assistance Program provides a maximum of three in-person or virtual sessions, per issue, per year.

Employee Assistance Program Contact Information	
Website	guidanceresources.com
WebID	NYLGBS
Phone Number	1-800-344-9752

Pet Insurance | MetLife

Pet Insurance | MetLife
No matter what unpredictable antics your furry family member gets into, your family isn't complete without them. With MetLife Pet Insurance, you can feel confident that their health and your wallet are protected if you're faced with an unexpected trip to the vet.

- Flexible coverage with up to 100% reimbursement and freedom to visit any U.S. licensed vet
- Available optional Preventive Care coverage
- 24/7 access to Telehealth Concierge Services
- MetLife Pet mobile app to submit and track claims and manage your pet's health and wellness

To get a quote or enroll, visit **www.metlife.com/getpetquote or call 1-800-GET-MET8.**

EmPower Wellness Program

At DCC Propane, we value each of our employees and consider your health and wellbeing one of our top priorities. All DCC Propane employees are eligible to participate in the company's Wellness Program, titled EmPower Wellness, powered by WellRight. The program includes activities to help you form healthy habits and enhance your wellbeing.

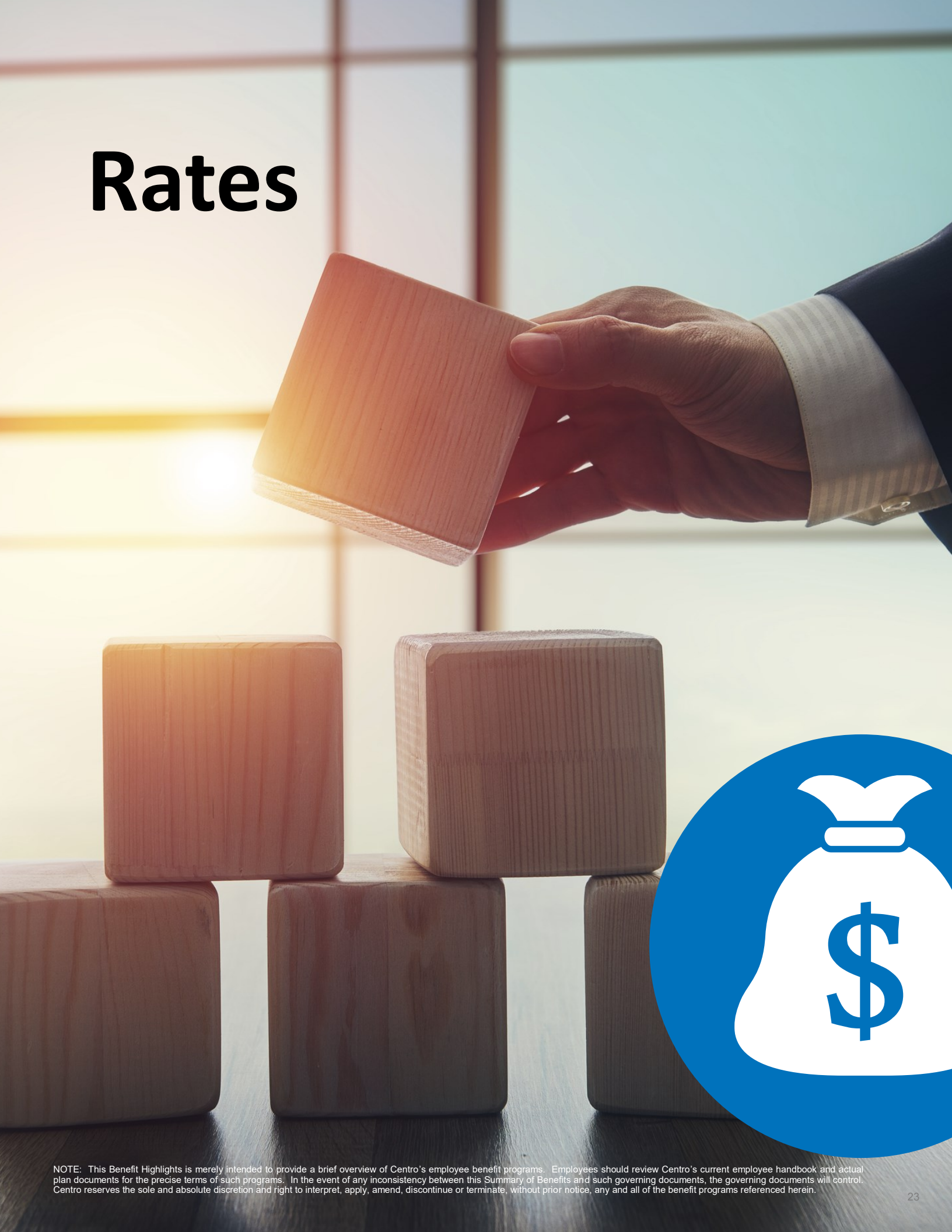
Participate in our wellness program to be rewarded for completing wellness activities from the following categories.

- Baseline Activities - Biometric screening, health risk assessment, & welcome webinar
- Preventive Care - Annual physical, dental visits, eye exam, vaccines, & preventive exams
- Annual Activities - Daily steps, organized race, Healthy U courses, fit-for-fidelity, & virtual 5K
- Wellness Challenges - Quarterly company-wide wellness challenges
- Personal - Choose from hundreds of Welllness challenges to help you achieve your goals!

* *Earn up to $500 in your HSA for HDHP plan members and anyone not on the HDHP plan can earn up to $250 in a cash bonus

To get started, visit dccpropane.wellright.com or scan the QR code below and sign in or select "register." Download the WellRight app to participate conveniently from your phone!

Rates



NOTE: This Benefit Highlights is merely intended to provide a brief overview of Centro's employee benefit programs. Employees should review Centro's current employee handbook and actual plan documents for the precise terms of such programs. In the event of any inconsistency between this Summary of Benefits and such governing documents, the governing documents will control. Centro reserves the sole and absolute discretion and right to interpret, apply, amend, discontinue or terminate, without prior notice, any and all of the benefit programs referenced herein.

Rates

Medical Insurance Rates - Wellness

High Deductible PPO $2,000		
Enrollment Tier	**Monthly**	**Biweekly**
Employee Only	$254.74	$117.57
Employee & Spouse	$534.95	$246.90
Employee & Child(ren)	$484.01	$223.39
Family	$764.22	$352.72
High Deductible PPO $3,500		
Enrollment Tier	**Monthly**	**Biweekly**
Employee Only	$179.19	$82.70
Employee & Spouse	$376.29	$173.67
Employee & Child(ren)	$340.45	$157.13
Family	$537.56	$248.10
High Deductible PPO $5000		
Enrollment Tier	**Monthly**	**Biweekly**
Employee Only	$0.00	$0.00
Employee & Spouse	$245.64	$113.37
Employee & Child(ren)	$222.25	$102.58
Family	$350.92	$161.96

Beginning in 2025 there will be a $100 surcharge on ALL of the plans for those not actively participating in the EmPower Wellness program by May 31, 2025. To be considered active, you must be enrolled and have submitted either the doctor affidavit for a doctor visit from August 1, 2024 to May 31, 2025, or have completed the FREE biometric exam through the EmPower Wellness/Wellright Program.

Tax-free Annual Contribution	Employee Only	Family
2025 Company Contribution $2,000 Plan	$250	$500
2025 Company Contribution $3,500 & $5,000 Plans	$500	$1,000

2025 IRS Maximum Contribution	Employee Only	Family
Maximum HSA Contribution (includes employer contributions)	$4,300	$8,550
Catch-up Contribution (Age 55 and Older)	$1,000*	

Rates

Dental Insurance Rates

Enrollment Tier	Monthly	Biweekly
Employee Only	$15.50	$7.15
Employee & Spouse	$30.00	$13.85
Employee & Child(ren)	$33.00	$15.23
Family	$46.00	$21.23

Vision Insurance Rates

Enrollment Tier	Monthly	Biweekly
Employee Only	$4.24	$1.96
Employee & Spouse	$8.48	$3.91
Employee & Child(ren)	$9.07	$4.19
Family	$14.49	$6.69

Voluntary Product Rates

Accident Insurance Rates

Enrollment Tier	Monthly	Biweekly
Employee Only	$6.47	$2.99
Employee & Spouse	$10.99	$5.07
Employee & Child(ren)	$15.68	$7.24
Family	$23.05	$10.64

Hospital Indemnity Rates

Enrollment Tier	Monthly	Biweekly
Employee Only	$15.25	$7.04
Employee & Spouse	$36.83	$17.00
Employee & Child(ren)	$25.64	$11.83
Family	$49.75	$22.96

Other Voluntary Product Rates

Vol. Life / AD&D and Critical Illness rates are based on age and additional demographic information. Refer to carrier plan documents for rate tables and calculation instructions.

Carrier Information

Carrier Information

Medical BCBSIL	
Carrier	BlueCross BlueShield
Website	www.bcbsil.com
Phone Number	1-877-301-4392
Policy Number	209840

Dental	
Carrier	Delta Dental
Website	www.deltadentalil.com
Phone Number	1-800-323-1743
Network	PPO Plus Premier
Policy Number	20533

Employee Assistance Program	
Carrier	New York Life
WebID	NYLGBS
Website	guidanceresources.com
Phone Number	1-800-344-9752

Health Savings Account	
Carrier	HSA Bank
Website	www.hsabank.com
Phone Number	1-866-471-5275

Vision	
Carrier	VSP
Website	www.vsp.com
Phone Number	1-800-877-7195
Network	VSP Advantage
Policy Number	40160982

Basic Life and AD&D Insurance	
Carrier	New York Life
Website	www.newyorklife.com/group-benefit-solutions/forms
Phone Number	1-888-842-4462

Voluntary Term Life and AD&D Insurance	
Carrier	New York Life
Website	www.newyorklife.com/group-benefit-solutions/forms
Phone Number	1-888-842-4462

Short & Long-Term Disability Insurance	
Carrier	New York Life
Website	www.newyorklife.com/group-benefit-solutions/forms
Phone Number	1-888-842-4462

Human Resources Contact Information	
Contact	Tylene Kami, Vice President Human Resources
Email Address	tylene.kami@dccpropane.com
Phone Number	1-217-579-0206

2025 Important Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page (30) for more details.

DCC PROPANE, LLC

Health and Welfare Benefits Annual Notice Packet

For the 2025 Plan Year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- Medicare Part D Creditable Coverage Notice
- HIPAA Special Enrollment Rights Notice
- HIPAA Notice of Privacy Practices
- Children's Health Insurance Program (CHIP) Notice
- Women's Health and Cancer Rights Act (WHCRA) Notice
- Newborns' Mothers Health Protection Act (NMHPA) Notice
- General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact Human Resources.

Health and Welfare Benefits Annual Notice Packet

Medicare Part D Creditable Coverage Notice

Important Notice from DCC Propane About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with DCC Propane and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **DCC Propane has determined that the prescription drug coverage plans offered by BlueCross BlueShield are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan while enrolled in DCC Propane coverage as an active employee, please note that your DCC Propane coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in DCC Propane coverage as a former employee.

You may also choose to drop your DCC Propane coverage. If you do decide to join a Medicare drug plan and drop your current DCC Propane coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with DCC Propane and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through DCC Propane changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

Medicare Part D Creditable Coverage Notice Continued

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender: DCC Propane
Contact--Position: Tylene Kami, Vice President Human Resources
Address: 204 N. State Route 54, Roberts, IL 60962
Phone Number: 217-395-2281

Health and Welfare Benefits Annual Notice Packet

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in DCC Propane group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPAA Notice of Privacy Practices

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

DCC Propane sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of DCC Propane, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

1. your past, present or future physical or mental health or condition;
2. the provision of health care to you; or
3. the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by DCC Propane, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the DCC Propane HIPAA Privacy Officer.

DCC Propane, LLC
Attention: HIPPA Privacy Officer
204 N State Route 54
Roberts, IL 60962

Effective Date

This notice as revised is effective July 31, 2024

HIPAA Notice of Privacy Practices Continued

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet at [insert intranet address]. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment
We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

HIPAA Notice of Privacy Practices Continued

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

HIPAA Notice of Privacy Practices Continued

Special Situations Continued

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

1. the individual identifiers have been removed; or
2. when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

HIPAA Notice of Privacy Practices Continued

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
2. treating such person as your personal representative could endanger you; or
3. in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

HIPAA Notice of Privacy Practices Continued

Your Rights
You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period DCC Propane has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

HIPAA Notice of Privacy Practices Continued

Your Rights Continued

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

You have the following rights with respect to your protected health information:

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

Health and Welfare Benefits Annual Notice Packet

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) Continued

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremiumassistance@accenture.com

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) Continued

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) Continued

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program| Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Health and Welfare Benefits Annual Notice Packet

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact Human Resources.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of COBRA Continuation Coverage Rights
Continuation Coverage Rights Under COBRA

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. 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 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 for COBRA continuation coverage.

Health and Welfare Benefits Annual Notice Packet

Model General Notice of COBRA Continuation Coverage Rights Continued

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

Model General Notice of COBRA Continuation Coverage Rights Continued

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. 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 parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Health and Welfare Benefits Annual Notice Packet

Model General Notice of COBRA Continuation Coverage Rights Continued

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Name of Entity/Sender: DCC Propane
Contact--Position: Tylene Kami, Vice President Human Resources
Address: 204 N. State Route 54, Roberts, IL 60962
Phone Number: 217-395-2281

Health and Welfare Benefits Annual Notice Packet

HIPAA Notice of Availability of Notice of Privacy Practices

The DCC Propane Group Health Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources.

HIPAA Wellness Program Reasonable Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

EEOC Wellness Program Notice

Notice Regarding Wellness Program
EmPower Wellness is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations. However, employees who choose to participate in the wellness program will receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

EEOC Wellness Program Notice Continued

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and DCC Propane may use aggregate information it collects to design a program based on identified health risks in the workplace, EmPower Wellness will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are a registered nurse, a doctor, or a health coach in order to provide you with services under the wellness program.

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

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

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

Your Rights and Protections Against Surprise Medical Bills Continued

You are protected from balance billing for:
Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:
- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - » Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - » Cover emergency services by out-of-network providers.
  - » Base what you owe the provider or facility (cost-sharing) on what it would pay an in□network provider or facility and show that amount in your explanation of benefits.
  - » Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills.