Dominion Energy Ohio
UWUA Local G555

Dental
Summary Plan Description

INTRODUCTION

Dominion Energy offers a Dental Plan that provides coverage for checkups, cleanings and other dental services for you and your covered dependents.

The Plan provides two levels of benefits, Standard benefits and Network benefits. The Standard level of benefits is based on a portion of the reasonable and customary charges for various local areas as determined by the Claims Administrator. You may obtain services from any dentist and receive benefits under the Standard level. In addition, some dentists participate in the MetLife dental network, and have agreed to discounted fees. If you use a network dentist, you should not be responsible for any additional charges above the deductible and coinsurance amounts under the Plan's Network level of benefits. However, when you use a dentist not participating in the network, you may be responsible for additional charges. If your provider charges more than the amount allowed by the Plan, you are responsible for the balance of the bill.

Benefits described in the Summary Plan Descriptions (SPDs) are current as of the date indicated at the bottom of the page. Dominion Energy may subsequently provide additional materials that supplement, update or amend the SPDs which will provide you with information regarding changes to your benefits.

Please see the "Additional Information" Summary Plan Description document for details on other rights pertaining to your participation in Dominion Energy's Benefit Plans.

TABLE OF CONTENTS

ELIGIBILITY

All active Local G555 employees are eligible to enroll for dental benefits.

Dependents
You may also enroll your eligible dependents. Only the following individuals may be enrolled in the Plan as your dependent(s):

- Your **spouse,** the person to whom you are legally married and for whom you have a valid government issued marriage certificate.

- Your **children**, regardless of marital status, (including natural children, legally adopted children, children placed with you for adoption, foster children and stepchildren) who are under age 26.

- Your **disabled children** age 26 or older, provided:
  - They became disabled before age 26;
  - They were enrolled in the Plan at the time they became disabled (or, in the case of a newly-hired employee with a child who is already disabled, the child is enrolled immediately upon the employee's employment);
  - They remain continuously enrolled in the plan following the disability; and
  - They qualify as your dependent for tax purposes (i.e. you can claim him or her as a dependent on your federal income tax return for the year).*

  For this purpose, "disabled" means permanently and totally disabled by Social Security Administration standards, which generally means that the child is very seriously limited in his or her activities by reason of a medically determinable physical or mental impairment that can be expected to result in death or to last for at least 12 months.

- Your **legal ward** under age 26 for whom you are appointed legal guardian or legal custodian, provided that the individual qualifies as your dependent for tax purposes.*

Dependents other than your children who are under age 26 who are serving in the military of any country cannot be covered under the Plan. Children of domestic partners also cannot be covered under the Plan, unless they are otherwise your adopted children or you have legal guardianship.

These rules for dependent status can be very complicated. It is your responsibility to ensure that your disabled child (age 26 or older) or legal ward qualifies as your dependent for tax purposes before enrolling or continuing to enroll him or her in the Plan. For a more detailed explanation of the requirements for tax dependent status, see IRS Publication 17, Your Federal Income Tax, available at www.irs.gov.

Domestic Partner
You also may enroll your domestic partner on an after-tax basis. You pay the full cost of coverage for your domestic partner. There is no Dominion Energy subsidy toward the cost of this coverage. You may cover another person as a domestic partner if both you and the domestic partner:

- Are age 18 or older;
- Have resided with each other for at least six months before the effective date of coverage and intend for the relationship to be of indefinite duration;
- Are not married to anyone else or involved in another domestic partner relationship;

- Share financial responsibilities through joint ownership or lease responsibilities of your residence, and/or have named each other as beneficiaries under life insurance policies or wills;
- Are not related by blood to such a degree that marriage would be prohibited under applicable state law (without regard to gender); and
- Are competent to make contracts (i.e., are not considered incompetent because of physical or mental disability).

Eligibility Verification
All employees must provide, upon request, written proof of eligibility of their dependents who are covered or who are requesting coverage under the Plan. Such written proof of eligibility must be submitted within the timeframe communicated by the Plan Administrator. Such proof of eligibility may include, but are not limited to, marriage certificates, birth certificates, adoption certificates, and federal tax returns. Lack of response to the request for written documentation and/or documentation found to be fraudulent in nature may result in a loss of coverage as well as disciplinary action, up to and including termination of employment.

Coverage Categories
You can choose from the following levels of coverage:

- You Only
- You + Spouse/Domestic Partner
- You + Child(ren)
- You + Family, or
- You + Child(ren) and Domestic Partner.

You may choose to waive dental coverage. If you waive coverage, you cannot enroll in the Dental Plan until the next annual Open Enrollment, unless you experience a Qualifying Life Event.

When Spouse or Domestic Partner is a Dominion Energy Employee
If you and your spouse or domestic partner are both employees of Dominion Energy, you cannot be covered as both an employee and a dependent. Also, your children cannot be covered by both employees. When enrolling, you have two options:

- One employee can sign up for coverage with the other as a dependent; or
- Both employees can sign up for coverage separately (with only one employee enrolling eligible children as dependents).

ENROLLMENT

New Hire
Coverage starts on your first day of work with Dominion Energy. You have thirty-one (31) days to elect your dental coverage.

- If you enroll within 31 days following your first day of work, coverage starts on your first day of work;
- If you do not enroll within 31 days following your first day of work, you cannot enroll in the Dental Plan until the next annual Open Enrollment, unless you experience certain Qualifying Life Events.

You will be able to enroll electronically in the Dental Plan through Your Benefits Resources (YBR):

- Directly from DomNet once you've logged on to your computer at work.
    - From the DomNet homepage, select the "Your Benefits Resources" link in the "Key Company Links" section to link directly to your YBR account via single sign-on. First time users will need to create a user ID and password.
- Via the Internet at http://digital.alight.com/dominionenergy
    - You'll need to enter your YBR user ID and password. The first time you go to YBR, click on Register as a New User and identify yourself by entering the last four digits of your Social Security number and your date of birth. You'll then be prompted to create a user ID and password.

Enrollment must be completed within 31 days of your first day of work. You may also contact the Dominion Energy Benefit Center (DEBC) at 1-877-434-6996 with questions or if you prefer to enroll via telephone.

Qualifying Life Events
If you experience a Qualifying Life Event, you may be permitted to change your dental coverage elections during the middle of a plan year without waiting until the next Open Enrollment period. Depending on the event, you can add or drop coverage or change your enrollment level (e.g., You Only to You + Family coverage).

An event is considered a Qualifying Life Event only if it affects your, your spouse's or domestic partner's, or your child's eligibility under this Plan or the dental plan of another employer. Changes you make following a Qualifying Life Event must be on account of and consistent with the event.

Following is a listing of the types of changes that are permitted following the various Qualifying Life Events.* In addition to the changes described below, you may drop coverage for your domestic partner at any time during the year, regardless of whether you experience a Qualifying Life Event.

Event	Enrollments Permitted	Cancellations Permitted
Dependent child events		
Birth, adoption, placement for adoption, appointment of legal guardianship, or death	• Add newly eligible child • Enroll self, spouse or domestic partner, newly eligible child and other child(ren)	• Drop deceased child
Satisfying or ceasing to satisfy eligibility requirements	• Add newly eligible child and other children	• Drop newly ineligible child
Qualified Medical Child Support Order	• Add child(ren) required by QMCSO • Enroll self, and child(ren) required by QMCSO	• Drop child(ren) if QMCSO requires spouse to provide coverage (and spouse does so) •
Domestic partner events		
Satisfying or ceasing to meet domestic partner eligibility requirement (including death of domestic partner)	• Add newly eligible domestic partner	• Drop newly ineligible or deceased domestic partner

Event	Enrollments Permitted	Cancellations Permitted
Domestic partner's change in employment or benefit eligibility status**	• Add domestic partner who lost coverage under their employer's plan	• Drop domestic partner who became covered under their employer's plan
Domestic partner's employer no longer contributes to their group dental coverage	• Add domestic partner	N/A
Employee events		
Employee's change in employment status**	• Enroll self, spouse or domestic partner, and children who became eligible under this Plan	• Drop self, spouse or domestic partner, and children who lost eligibility under this Plan
Other coverage events		
Open enrollment (non-calendar year) in other employer's plan	• Enroll self, spouse or domestic partner, and children whose coverage was dropped under other plan	• Drop self, spouse or domestic partner, and children whose coverage was added under other plan
Loss of governmental or tribal group dental coverage	• Add spouse, domestic partner or children who lost other coverage • Enroll self, spouse, domestic partner, or children who lost other coverage	N/A
Relocation of spouse or domestic partner or children to or from another country	• Add spouse or domestic partner and children who moved to the U.S.	• Drop spouse or domestic partner and children who moved out of the U.S.
Spouse events		
Marriage	• Add spouse and children, including new stepchildren • Enroll self, spouse and children	• Drop self and children, if coverage is obtained under spouse's plan
Divorce, annulment or death of spouse	• Add children, if coverage is lost under spouse's plan • Enroll self and children, if coverage is lost under spouse's plan	• Drop spouse
Spouse's change in employment or benefit eligibility status **	• Add spouse and children who lost coverage under spouse's plan • Enroll self, spouse and children who lost coverage under spouse's plan	• Drop self, spouse and children who became covered under spouse's plan

Event	Enrollments Permitted	Cancellations Permitted
Spouse's employer no longer contributes to their group dental coverage	• Add spouse and children who lost subsidy under spouse's plan • Enroll self, spouse and children who lost subsidy under spouse's plan	N/A

* These rules will be interpreted and administered in accordance with IRS rules and regulations.
**Changes in employment status that cause a gain or loss of eligibility under this Plan or your spouse's or domestic partner's plan may include: termination or commencement of employment, commencement of or return from unpaid leave, change in status such as full-time to part-time (or vice versa) and similar events. FMLA or USERRA rules may also apply if unpaid leave is family and medical leave or military leave, respectively.

IMPORTANT! When you have a Qualifying Life Event, you must contact the Dominion Energy Benefit Center at 1-877-434-6996 **within 31 days of the event**.* If your event does not allow a benefit change, you must wait until the next annual Open Enrollment or another Qualifying Life Event to make a change to your benefits.

* The enrollment period to add dependent children is 60 days in the event of the birth, adoption or placement for adoption of your dependent child(ren); eligibility for premium assistance under the plan through a state children's health insurance program (CHIP); or the termination of Medicaid or CHIP coverage due to loss of eligibility. The 31-day period remains in effect for adding dependents under all other qualifying life events.

Qualifying Life Event changes take effect as follows:

- Adding coverage – coverage begins retroactive to the date of the Qualifying Life Event
- Canceling coverage – your last day of coverage is the last day of the month in which your Qualifying Life Event occurred

Open Enrollment
Annual Open Enrollment takes place in the fall of each year. It is the time when you can change your dental benefit elections. Changes you make at Open Enrollment are effective the following January 1.

Rehire/Reinstate
If you terminate employment and return to work for Dominion Energy in an eligible category for benefits enrollment, your benefit enrollment election depends on the number of days you did not work for Dominion Energy:

- If you return to work in 31 days or less from the termination date, your benefit elections are the same elections that were in effect on the termination date. If the same benefit election(s) are not available, you are eligible to make a new election, but only for the plan that changed, if another plan is available; or
- If you return to work after 31 days from the termination date, you are required to make new benefit elections.

Paying For Coverage
You and Dominion Energy share the cost of your dental coverage. Dominion Energy contributes a significant share of the cost. You pay your share through payroll contributions, deductibles and copayments. Your payroll contributions are

pre-tax for coverage levels of You Only, You + Child(ren), You + Spouse, and You + Family. Pre-tax means your contributions are automatically deducted from your pay before Social Security, federal and, in most cases, state taxes are deducted from your paycheck. Your contributions for Domestic Partner coverage are on an after-tax basis and are in addition to your pre-tax contributions.

HOW THE DENTAL PLAN WORKS

Dominion Energy offers one Dental Plan with two levels of benefits. Each time you receive dental care your benefit is determined by the dentist who provides care and the service you receive.

Standard Dental Benefits
The Standard dental benefit provides comprehensive dental protection, including 100% of reasonable and customary charges (R&C) for preventive care, 80% of R&C for restorative, 50% of R&C for prosthodontic and 50% of R&C for orthodontia. These services may be obtained from any dentist. Benefits are paid at a competitive R&C allowance.

Network Dental Benefits
If you use a MetLife participating network dentist, the Network dental benefit provides 100% for preventive care, 90% for restorative, 60% for prosthodontic and 60% for orthodontia. Network dentists have agreed to accept a negotiated fee as full payment for covered services. This means you are not responsible for any additional costs, provided that the services are covered by the Plan, except when:

- You or your dependent has exceeded the annual maximum or lifetime maximum amount for specified services; or
- You or your dentist decides to use services/materials that are more expensive than those customarily furnished by most dentists. In these cases, MetLife may pay an allowance appropriate for a less expensive, generally accepted service or material.

MetLife has a nationwide network of participating dentists to choose from. To find a provider in your area, you can:

- Access the MetLife directory by visiting the MetLife web site at www.metlife.com/mybenefits. You can use an on-line directory to check the participation status of your dentist or to search for a new participating dentist.
- Call 1-800-942-0854 to speak to a MetLife customer service representative.

ID Cards
After you enroll, you are sent two dental identification (ID) cards with a unique identifier that is not your social security number. Your ID cards signifies that you have coverage under the Dental Plan. You and your dentist can use this unique identifier number when calling MetLife, requesting a pre-certification or filing a claim for benefits.

If you lose your card, or need an additional card, contact MetLife at 1-800-942-0854.

Deductible
The Dental Plan requires that you pay an annual deductible of $25 per person or up to $75 per family before the Plan pays for most services. Preventive services and orthodontics are not subject to the annual deductible.

The family deductible can be met by any combination of covered expenses incurred by you and at least one other covered family member. One person can never incur deductible expenses above the individual limit.

The deductible can be met with Standard and/or Network covered expenses.

Copayments
The Dental Plan requires that you share in the cost of paying for most covered expenses after you've met your deductible. If you use a network provider, the Plan pays a percentage of a negotiated fee. For a non-network provider, the Plan pays a percentage of reasonable and customary (R&C) charges.

For more information, see "Summary of Benefits."

Maximum Benefit
The Dental Plan provides up to $1,500 in dental benefits (Standard and Network combined) per person per calendar year, and orthodontic benefits up to $1,500 per child per lifetime.

Summary of Benefits
The following chart compares the key features of the Dental Plan:

PLAN FEATURES	COVERAGE LEVELS	
	Standard Benefit	**Network*** Benefit
Annual Deductible	$25 per individual; $75 per family	
Annual benefit maximum (all services except orthodontia)	$1,500 per person	
COVERED EXPENSES		
Preventive	100% R&C** no deductible	100% of network negotiated cost, no deductible
Restorative	80% R&C** after deductible	90% of network negotiated cost after the deductible
Prosthodontics	50% R&C** after deductible	60% of network negotiated cost after the deductible
Orthodontics	50% R&C** no deductible	60% of network negotiated cost no deductible
	Up to a $1,500 lifetime benefit per child	

*If you use a MetLife Network dentist, you are not responsible for covered expenses in excess of your copayment amounts to the Plan maximums.

**R&C is the amount considered to be reasonable in your geographic area for the same service as determined by MetLife. The Plan does not cover charges over R&C. You may be billed by the provider for the amount over R&C.

The Standard and Network benefits cover the cost of generally accepted services and materials. If you and/or your dentist elect services/materials that are more expensive, the Plan pays a percentage up to the generally accepted service/materials and you are responsible for the additional cost. See "Pre-Treatment Estimate of Benefits" in this section for more information.

Pre-Treatment Estimate of Benefits
MetLife can provide a "Pre-Treatment Estimate of Benefits," that can help you and your dentist know exactly how much the Plan will pay for certain treatments, services, and materials.

If you or a covered dependent needs treatment that may cost $100 or more, you should file a pre-treatment estimate of benefits. Use the dental claim form and have your dentist write down a full description of the planned treatment. You or your dentist can send the form to MetLife. MetLife reviews the form and lets you and your dentist know what benefits will be paid by the Plan.

In some cases, MetLife may recommend a less costly course of treatment that it believes is a standard accepted service/material that is just as effective as the treatment proposed by your dentist. If MetLife recommends such a course of treatment, the Plan pays benefits only for the lower-cost course of treatment. Of course, you ultimately decide which course of treatment to follow, but it is important for you to know what the Plan will pay and what you will pay.

If you do not file for a pre-treatment estimate of benefits, the Plan still pays only the R&C for the standard accepted service/materials for the treatment. However, you do not have the opportunity to find out about other methods of treatment that might have been available.

WHAT THE PLAN COVERS

The Dental Plan covers a wide range of dental treatments and services.

- Dental benefits are based on the materials and method of treatment that are the least costly and meet generally accepted dental standards (according to MetLife). In some cases MetLife may recommend a less costly course of treatment that it believes is a standard accepted service/material that is just as effective as the treatment proposed by your dentist. If MetLife recommends such a course of treatment, the Plan pays benefits only for the lower-cost course of treatment.
- If a tooth can be repaired to generally accepted dental standards by a less costly method than an inlay, onlay, crown or gold foil, dental benefits are based on the MetLife determination of the adequate method of repair that is the least costly.
- When multiple related services are performed on the same date, MetLife considers the most comprehensive service when determining payment of benefits. For example, when bitewing x-rays and a panorex x-ray are performed on the same date, MetLife uses the more comprehensive panorex (full mouth) x-ray to determine benefits.

Just because a service is prescribed by a provider does not mean that the service is covered under the Dental Plan as determined by MetLife.

Preventive
Preventive care includes services that help you and your covered dependents avoid serious dental problems in the future.

Charges for preventive care are paid at 100% of reasonable and customary (R&C) for Standard benefits and 100% for Network benefit coverage, and are not subject to the annual deductible.

Covered Preventive care services include:

- 2 routine exams per calendar year;
- 2 cleanings per calendar year;
- Complete full-mouth x-ray every 36 months;
- Fluoride treatments;
- Sealants for children under age 19 (once in a lifetime, permanent molars only);
- Space maintainers for children under age 19;
- Emergency treatment for pain. An emergency oral exam is not payable under the Plan as a separate procedure when performed in conjunction with emergency treatment to alleviate pain or when performed on the same day as treatment to correct the condition that caused the emergency;
- Supplementary bitewing* x-rays once in a six-month period; and
- Surgical removal of impacted teeth.**

* A bitewing is a dental x-ray that shows the crown halves of the upper and lower jaw.

** If you are enrolled in the Dominion Energy Medical Plan. You should first file with the Medical Plan. After the claim is processed under the Medical Plan, if any charges were not paid, you can file with the Dental Plan. Complete a dental claim form showing the total fee charged (not the balance due). Attach the Anthem Explanation of Benefits (EOB) to the dental claim form and submit it to MetLife. The Dental Plan pays up to 100% of R&C for unpaid expenses.

Restorative

Generally, restorative care is dental treatment to restore a tooth or the tissue around it. Fillings and simple extractions are common forms of restorative care. After the deductible has been satisfied, restorative care is paid at 80% under the Standard benefit and 90% under the Network benefit.

Covered restorative care includes:

- Extractions- if the extraction is in connection with orthodontics, the Standard benefit is 50% of R&C, and the Network benefit is 60%;
- Fillings of amalgam, silicate, acrylic, synthetic porcelain, or composite;
- Gold fillings (paid only if the tooth cannot be restored by commonly used filling material);
- Oral surgery that is in connection with orthodontics is 50% of R&C under the Standard benefit and 60% under Network benefits;
- Relining or rebasing of dentures** (this benefit is paid only after six months following the installation of an initial or replacement denture but not more than once in any 36-consecutive-month period);
- Periodontal care (treatment of gums);
- Endodontics, including root canal therapy;
- Nightguard;
- Antibiotics (by injection only);
- Repair and recementing of crowns, inlays, onlays*, bridgework, or dentures**;
- Anesthetics;

- Temporomandibular Joint (TMJ) therapy and the TMJ appliance (adjustments to the appliance are not covered); and
- Periodontal cleanings if related to periodontal surgery/active therapy (these cleanings are in addition to the two preventive cleanings per calendar year).

*An **inlay** is a filling that is cemented into place to fit a tooth cavity. An **onlay** is like a filling but covers the entire surface of a tooth. It is often used to restore a part of a tooth or to increase the height of a tooth. A **crown** is the portion of the tooth that is covered by enamel.
A **denture is a device that replaces missing teeth.

Prosthodontics
Prosthodontics refers to the replacement of natural teeth with bridgework or dentures. After the deductible has been satisfied, charges for Prosthodontic care are paid at 50% of R&C under the Standard benefit, and 60% under the Network benefit.
Covered prosthodontic care includes:

- Implants;
- Inlays, onlays or crown restorations (paid only if the tooth cannot be restored by commonly used filling material);
- The addition of teeth to an existing partial denture or bridgework;
- Installation of fixed bridgework*. Includes inlays, onlays, crowns and abutments** if part of the bridgework. Otherwise, it is classified as restorative; and
- Initial installation of partial or full removable dentures and any adjustments during the six-month period following installation.

* A **fixed bridge** is a partial denture that is retained with crowns or inlays cemented to natural teeth. A **fixed removable bridge** is a bridge that can be removed by a dentist but not by a patient. A **removable bridge** is a partial denture that is retained by attachments, usually clasps, which permit removal of the denture.
An **abutment is a tooth or root that retains or supports a bridge or fixed removable artificial replacement of natural teeth or other structures.

Limits on prosthodontic care includes:

- Plan pays to replace only those teeth that are lost while covered under the Plan;
- The plan will cover replacement crowns, inlays and onlays once every 5 years as needed;
- Prosthodontic care for the addition of teeth to an existing denture or bridgework is covered. However, benefits are paid only if service is required to replace teeth extracted after the existing denture or bridgework is installed;
- Benefits are paid for replacing an existing denture or bridgework only if the existing denture or bridgework is more than five years old and cannot be made serviceable; and
- The existing denture must be an immediate temporary denture that cannot be permanent, and replacement by a permanent denture must take place within 12 months of the date of installation.

Orthodontics
Orthodontic care covers the straightening of teeth with braces if you are under age 19, or for your covered dependents under age 19.

Orthodontic care is paid at 50% of the R&C under the Standard benefit, and 60% under the Network Benefit, and is not subject to the annual deductible. This includes oral surgery that is part of orthodontic treatment and x-rays taken by an orthodontist.

Orthodontic services associated with the correction of a cleft lip or cleft palate are excluded from coverage under the Plan.

Orthodontic benefits from the Plan are limited to a $1,500 lifetime maximum per covered individual.

The following is an example of how orthodontic services are paid under the Dental Plan.

$2,500	Estimated Charges for 24 months
x 20%	Allowed for Installation
$ 500	Installation Charge
	Standard benefit: The Plan pays 50% R&C of the installation or $250*
	Network benefit: The Plan pays 60% of network negotiated cost of the installation or $300
$2,500	Estimated Charges
- 500	Installation Charges
$2,000	Balance of Charges
$2,000	Divided by 24 months = $83.33
	Standard Benefit: 50% or $41.67 paid monthly by MetLife
	Network benefit: 60% or $50.00 paid monthly by MetLife

***Note:** The $1,500 lifetime orthodontic maximum includes the Plan's payment for the installation charges.

WHAT TO DO IN AN EMERGENCY

If you have an urgent dental condition, you should seek treatment at the nearest dentist's office, regardless of whether the dentist is a network provider. You do not need prior approval. However, keep in mind that the Plan only pays for covered benefits.

The Dental Plan does not cover services provided in a hospital, surgical center, or urgent care facility. You are covered for procedures performed in a dental office by a licensed dentist, provided the procedures are covered under the Plan.

WHAT THE PLAN DOES NOT COVER

Some of the items that are not covered under the Dental Plan are listed below. This is not an all-inclusive list. If you have a question about whether a treatment or service is covered under the Plan, you should contact MetLife Customer Service at 1-800-942-0854, prior to receiving the service.

- Services or supplies covered by one of Dominion Energy's group medical plans, Workers' Compensation, Employee's Liability Law, or any government health plan;
- Expenses for services rendered through a medical department, clinic, or similar facility provided or maintained by your employer;

- Treatment by someone other than a licensed dentist, except for cleaning or fluoride treatment by a dental hygienist;
- Use of veneer crowns (thin crowns) or similar material to replace teeth, other than the ten upper and ten lower front teeth;
- Services or supplies for cosmetic purposes such as capping healthy, natural teeth;
- Any charges for treatment of conditions resulting from war or act of war;
- Services ordered before your coverage began, or delivered or installed more than 90 days after your coverage ends;
- Replacement of lost or stolen dentures or orthodontic retainers;
- Replacement or repair of an appliance used to straighten teeth;
- Penalties for failure to keep a scheduled dental appointment;
- Services or supplies that are unnecessary according to accepted standards of dental practice *or* do not meet those standards *or* are experimental in nature;*
- Duplicate dentures or appliances;
- Oral hygiene and dietary instructions or an educational program, such as plaque control (sealants are covered up to age 19);
- Expenses for dentures or bridgework (including inlays and crowns to form abutments) replacing teeth you lost before you were covered under the Plan;
- Braces for covered individuals age 19 or older;
- Completion of insurance forms;
- Analgesia – nitrous oxide;
- Orthodontic services associated with correction of a cleft lip or cleft palate;
- Services provided in a hospital, surgical center or urgent care facility; and
- When multiple related services are performed on the same date, MetLife will consider the most comprehensive service when determining payment of benefits.

* No benefits are provided under this Plan for experimental treatments, procedures, and therapies. For these purposes, “experimental” means any medical procedure, treatment, or course of treatment that is (a) not proven in an objective manner to have benefit for the patient, (b) restricted to use at medical facilities engaged primarily in carrying out scientific studies, or (c) of questionable medical effectiveness. In determining whether a particular procedure is experimental, the Plan Administrator shall consider (among other things) commissioned studies, opinions, and references to or by the U.S. Food and Drug Administration, the U.S. Department of Health and Human Services, the Centers for Medicare and Medicaid Services (formerly HCFA), the National Institutes of Health, and any other association or federal program or agency that has the authority to approve medical testing or treatment.

COORDINATION OF BENEFITS

Coordination of benefits occurs when you have dental coverage through Dominion Energy and another group dental plan. Under the Dental Plan’s coordination of benefits provision, benefits from this and any other plan are coordinated so that benefits from both plans will not exceed 100% of expenses actually incurred.

If you are enrolled in the Dental Plan as an employee, this Plan is primary and pays benefits first for your expenses. Any other group dental coverage you have is considered secondary and pays benefits second.

If your spouse or domestic partner works and has coverage through his or her employer, that coverage is the primary coverage for your spouse or domestic partner and pays benefits first for his or her expenses. If he or she also is covered under the Dominion Energy Dental Plan, it is considered secondary for your spouse or domestic partner and pays benefits second.

The Dominion Energy Dental Plan is considered the primary plan for your other covered dependents, also covered by your spouse's or domestic partner's plan, only if your birthday is earlier in the year than your spouse's or domestic partner's. If you and your spouse or domestic partner share the same birthday, the Dominion Energy Dental Plan is the primary plan if your coverage under the Plan has been in effect longer than your spouse's or domestic partner's coverage under the other plan.

You will be asked to provide information about your other coverages. Failure to provide this information could result in a denial of claims.

This coordination of benefits provision does not affect any personal coverage purchased on your own.

FILING CLAIMS

You need to fill out claim forms for dental expenses. The *Dental Expense Claim Form* is available on dombenefits.com or by calling the Dominion Energy HelpLine at 1-877-947-4636. Complete a separate claim form for each patient.

Instructions for filing are on the claim form. You can save time and speed payment by completing your part of the form before giving it to your dentist.

Many dentists will file the form with the insurance company for you. The carrier's name and address are on the form.

It is important that claims are filed as soon as possible. It is your responsibility to make sure that claims are filed in a timely manner. Only claims submitted within 15 months from the date of service are considered for payment.

Remember that dental treatments that are expected to cost $100 or more should be reviewed by the insurance carrier before treatment begins. Please refer to the section "Pre-Treatment Estimate of Benefits."

If MetLife denies your claim, they will notify you of their decision within a reasonable period, not to exceed 30 days from the date they received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 15 additional days.

The notification of the claim denial will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal, if applicable.

Appeal and Review Process

Enrollment Review
You can request a review of an enrollment/coverage decision made by Dominion Energy. You must submit your request in writing to the Benefits Manager no later than 180 days after the date you received an enrollment/coverage decision. You can submit any additional documents or written comments you feel are relevant to your request, and you can review and request copies of relevant documents from Dominion Energy. The Benefits Manager will respond in writing within 60 days, unless special circumstances require an extension of up to 60 additional days to consider your request. You will be notified if any extension is needed.

> *NOTE: You should request your review as soon as possible, as missed (retroactive) employee contributions may be required.*

Dental Claim Appeals
If MetLife denies your claim, you may make two appeals of the initial determination. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the Explanation of Benefits form within 180 days of receiving MetLife's decision.

Appeals must be in writing and must include at least the following information:

- Name of Employee;
- Name of the Plan;
- Reference to the initial decision;
- Whether the appeal is the first or second appeal of the initial determination; and
- An explanation why you are appealing the initial determination.

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within 30 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criteria was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

If MetLife approves the claim on appeal, you will be notified in writing of the benefits paid. If any benefits within the reprocessed claim are denied, you will receive a written explanation.

Final Appeal with the Plan Administrator
If all levels of appeal have been exhausted with MetLife, the Dental Plan offers a voluntary level of appeal to the Dominion Energy Manager of Benefits. The purpose of the voluntary appeal procedure is to ensure that MetLife has received all necessary information and taken all appropriate steps to review your case. The Manager of Benefits does not review appeals if a medical judgment is involved. MetLife, as the Claims Administrator of the Dominion Energy Dental Plan, reviews and makes all medical determinations after consultation with a qualified medical professional.

You must exhaust your appeal rights with MetLife before filing a voluntary level of appeal with the Manager of Benefits. A voluntary level of appeal request must be submitted in writing within 180 days following the final determination of a claim by MetLife at the following address:

Dominion Energy
Manager, Benefits
5000 Dominion Blvd
Floor 1NE
Glen Allen, VA 23060

The Manager of Benefits will review the appeal and take into account all the information you submit, regardless of whether the information was considered at the time the MetLife coverage decisions were made. The Manager of Benefits will respond to your appeal request within 60 days after the receipt of your appeal request, unless special circumstances require an extension of time to review your appeal in which case a decision will be made within 120 days after the receipt of your appeal request.

You are not required to file a voluntary level of appeal prior to bringing a civil action in federal court to appeal an adverse benefit determination by MetLife. Dominion Energy waives any right to assert that you failed to exhaust your administrative remedies under ERISA if you do not elect to submit a voluntary level of appeal.

Dominion Energy agrees that any statute of limitations or other defense based on timeliness is tolled during the time a voluntary level of appeal is pending.

Upon request, Dominion Energy will provide you with additional information about the voluntary level of appeal process so that you may make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. A decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the Dental Plan. No fees or costs will be imposed on you as part of the voluntary level of appeal process.

Your Contact at Dominion Energy
If you have questions or concerns about how the Claims Administrator has processed your claim or a request for services, you should contact the Claims Administrator to understand how the claim was processed, how the Plan provisions apply, and to determine if you or your provider needs to provide additional information. Should you still have questions or concerns, you can contact Dominion Energy's Benefits Manager at the address below:

Dominion Energy.
Benefits Manager
5000 Dominion Blvd
Floor 1NE
Glen Allen, VA 23060

The Benefits Manager can assist in explaining the Claims Administrator's processes, or contact the Claims Administrator to obtain more details about how your claim was processed or facilitate the exchange of information between you and the Claims Administrator.

Action of the Administrative Benefits Committee
The Benefits Manager can ask Dominion Energy's Administrative Benefits Committee (ABC) to consider changes to the design of the Plan.

The Committee makes decisions to change or not change the Plan design. The ABC can consider proposed changes as they would apply to all Plan participants. The ABC will not modify the Plan on behalf of an individual claimant or review determinations of the Claims Administrator.

The Claims Administrator makes and reviews all determinations as to whether dental benefits are payable under the Plan (including decisions on standard accepted services/alternate benefits) and handles appeals of denied claims or services. Claims and appeals are handled by the Claims Administrator in accordance with Department of Labor regulations. The Claims Administrator has full discretionary authority and makes all final decisions on claims and appeals; and construes, interprets and enforces the terms of the Plan as it relates to claims and appeals. The Benefits Manager can monitor the Claims Administrator's claim and appeal process. The Benefits Manager does not review or overrule any individual determinations by the Claims Administrator.

SPECIAL COVERAGE RULES

There are a number of special coverage rules under the Dental Plan.

Leave of Absence
If you are granted a leave of absence without pay, the following options are available to you:

- Waive benefit coverage;
- Continue current benefit coverage by paying the employee contributions during your leave of absence; or
- Continue current benefit coverage, but have your benefit deductions accrue during your leave, in which case the total amount accrued will be due when you return to work.

Contact the Dominion Energy Benefit Center at 1-877-434-6996 before your leave begins to make the necessary arrangements to pay your contributions while on leave, or immediately after your leave ends to make repayment arrangements for any contributions

that accrued during your leave. Unless you make alternate payment arrangements upon your return to work, all accrued contributions will be deducted from your pay after your return to work.

When Coverage Ends
Your coverage under the Plan continues through the last day of the month in which any of the following occurs:

- Your employment with Dominion Energy terminates;
- You retire or are placed on disability status;
- You fail to meet the eligibility requirements;
- You fail to make the required contributions to the Plan; or
- Termination of the Plan causes coverage to end.

Coverage for your spouse/domestic partner or dependents under the Plan continues through the last day of the month in which:

- You cease to be covered under the Plan;
- You divorce your covered spouse (final decree must be granted; your children's coverage will continue);
- Your domestic partner no longer meets the eligibility requirements (see Eligibility section for details); or
- Your dependents cease to qualify as dependents under the terms of the Plan:
    - Coverage ends for children on the last day of the month during which they attain age 26.

If you die, coverage continues for your spouse/domestic partner and dependent children at no cost to them until the end of the month following the month in which your death occurred.

When coverage ends for your spouse/domestic partner or dependent children, you must contact the Dominion Energy Benefit Center at 1-877-434-6996 within 31 days of the event.

Dental coverage is not portable and cannot be converted to an individual policy if you leave Dominion Energy.

> *Note: If you terminate employment with Dominion Energy because all or a portion of the business unit in which you work is sold to a company that is not a Dominion Energy entity and you become an employee of the buyer, your coverage and the coverage of your spouse and eligible dependents under the Dominion Energy Dental Plan ends on your last day of employment with Dominion Energy provided you become eligible for coverage under the buyer's dental plan as of the closing date of the sales transaction.*

COBRA
You and your spouse, domestic partner or dependent children may be eligible to continue coverage under Dominion Energy's Dental Plan as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA). See the Additional Information SPD for details.

Extended Benefits
There may be other circumstances in which coverage under the Plan could be extended.

Whenever coverage is cancelled, any valid claim for a covered expense incurred before the date coverage was cancelled is processed. The Plan does not pay for services or supplies furnished after coverage terminates even if payments had been estimated before you left Dominion Energy. However, the Plan pays benefits for:

- A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the abutment teeth while you or your dependent was covered by the Plan and delivers and installs the device within three calendar months after the coverage stops;
- A crown if the dentist prepared the tooth for the crown while you or your dependent was covered by the Plan and installs the crown within three calendar months after the coverage stops; or
- Root canal therapy if the dentist opened the tooth while you or your dependent was covered by the Plan and completes the treatment within three calendar months after the coverage stops.

CHANGING OR TERMINATING THE PLAN

Except as set forth in the following paragraph, no changes affecting benefits provided under the Dental Plan may be made without the written consent of the Executive Committee of the Union.

Dominion Energy reserves the right to amend the Plan and revise the Summary Plan Description at any future date, without the consent of the Executive Committee of the Union for the following reasons: (1) to make nondiscretionary changes that are required to comply with federal and state laws, regulations and official regulatory guidance of general applicability, (2) to make changes in the organizations engaged to administer the plan, or (3) to update contact names, phone numbers, physical addresses, internet addresses or similar information. In the event of any such change, Dominion Energy shall provide written notice of the change to the Executive Committee of the Union within thirty (30) days before the effective date of the change, or as soon as practicable thereafter.

PLAN DOCUMENTS

This information has been prepared to describe the Dental Plan benefits that are available to you and your eligible dependents. If there is a conflict between this information and the official documents that govern the operations of the Dental Plan, those official documents govern.