Dominion Energy Ohio
UWUA Local G555

Vision
Summary Plan Description

INTRODUCTION

The Vision Plan provides coverage for routine eye examinations, lenses, and frames.

The Plan provides two levels of benefits, Out-of-Network and In-Network benefits. With Out-of-Network benefits, you use any vision provider you choose, submit claim forms, and receive a scheduled dollar amount for each covered service. You are responsible for any costs over that amount. If you use an EyeMed Vision Care Network provider, you receive benefits under the In-Network level and claim forms are not required.

The Vision Plan does not cover medical care for your eyes, such as for an eye infection or injury. This coverage is provided by your Medical Plan.

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.

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ELIGIBILITY

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

Dependents
You may also enroll your eligible dependents in vision benefits. Only the following individuals may be enrolled in the Plan as your dependents:

- 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, (defined as your natural children, legally adopted children, children placed with you for legal 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 19) 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 qualified as your dependents under the Plan.

*The 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 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
- You + Child(ren) and Domestic Partner.

You may choose to waive vision coverage. If you waive coverage, you cannot enroll in the Dominion Energy Vision 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 employed by Dominion Energy, you cannot be covered as both an employee and a dependent. Also, your children cannot be covered by both parents. When enrolling for vision benefits, 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 coverage:

- If you enroll within thirty-one days following your first day of work, coverage starts as of your first day of work; and
- If you do not enroll within thirty-one days following your first day of work, you cannot enroll in the Vision Plan until the next annual Open Enrollment, unless you experience a Qualifying Life Event.

You will be able to enroll electronically in the Vision 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 employment date. 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 vision 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 vision 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 (e.g., reaching age 26)	• 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)

Event	Enrollments Permitted	Cancellations Permitted
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
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 vision 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 vision 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

Event	Enrollments Permitted	Cancellations Permitted
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
Spouse's employer no longer contributes to their group vision 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 – your coverage takes effect 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 vision benefit elections. Changes you make at Open Enrollment are effective the following January 1.

Rehire/Reinstate
If you terminate employment and then 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 vision coverage. Dominion Energy contributes a significant share of the cost. Your contributions are pre-tax for coverage categories 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.

Additional Vision ID Cards
Additional vision ID cards may be obtained by calling EyeMed Vision Care's Customer Service number at 1-855-273-4537 and following the voice response system.

HOW THE VISION PLAN WORKS

The Vision Plan covers eye exams, prescribed corrective lenses (including contact lenses), and frames from any vision provider or the EyeMed Vision Care network of providers.

Out-of-Network
You can go to any provider of your choice and receive benefits at the Out-of-Network level of benefits. The Plan pays Out-of-Network benefits based on the total cost of an item or service up to a maximum scheduled amount for that item or service. You must pay the provider directly for all charges and then file a claim form.

In-Network
Vision care services received from an EyeMed Vision Care network provider are covered at the In-Network level of benefits and claim forms are not required.

To find a provider via the Web, go to the EyeMed Vision Care website at www.eyemedvisioncare.com and choose SELECT from the "Select Network" drop-down box. Enter your zip code and click 'Let's Go".

To find a provider by phone, call 1-855-273-4537 to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you.

Summary of Benefits
This chart illustrates the key features of the Vision Plan for 2019:

Plan Features	In-Network	Out-of-Network Reimbursement
Exam with Dilation as Necessary:	$0 Copay	Up to $55
Contact Lens Fit and Follow-up:		
Standard	Up to $40	N/A
Premium	10% off retail price	N/A
Frames:	$0 Copay; $80 Allowance; 20% off balance over $80	Up to $65
Standard Plastic Lenses:		
Single Vision	$0 Copay	Up to $60
Bifocal	$0 Copay	Up to $80
Trifocal	$0 Copay	Up to $100
Lenticular	$0 Copay	Up to $120
Standard Progressive Lens	$50 Copay	Up to $80
Premium* Progressive Lens	$76 - $88 Copay	
Tier 1	$76 Copay	Up to $80
Tier 2	$82 Copay	Up to $80
Tier 3	$88 Copay	Up to $80
Tier 4	%50 Copay; 80% of charge less $120 Allowance	Up to $80
Lens Options (paid by the member and added to the base price of the lens):		
UV Coating	$12 Copay	N/A
Oversize (Upcharge)	$0 Copay	N/A
Tint (Solid and Gradient)	$0 Copay	N/A
Standard Scratch Resistance	$15 Copay	N/A
Standard Polycarbonate – Adults	$30 Copay	N/A
Standard Polycarbonate – Children under 19	$0 Copay	N/A
Standard Anti-Reflective	$35 Copay	N/A
Polarized	$75 Copay	N/A
Photochromic/Transitions Plastic	$65 Copay	N/A
Premium* Anti-Reflective	$48 - $60 Copay	
Tier 1	$48 Copay	N/A
Tier 2	$48 Copay	N/A
Tier 3	$60 Copay	N/A
Glass Grey #3 (Rx Sun)	$0 Copay	N/A
Blended	$20 Copay	N/A
Intermediate	$30 Copay	N/A
Photochromic Glass	$20 Copay	N/A
High Index	$55 Copay	N/A
Other Add-ons and Services	20% off retail price	N/A
Contact Lenses instead of Eyeglass Lenses (allowance covers materials only):		
Conventional	$0 Copay; $110 Allowance: 15% off balance over $110	Up to $100
Disposables	$0 Copay; $110 Allowance; Balance over $110	Up to $100
Medically Necessary	$0 Copay; Paid-in-Full	Up to $100
LASIK and PRK Vision Correction Procedures:	15% off retail price OR 5% off promotional price	N/A
Additional Pairs:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Exam	Once every calendar year	
Frames	Once every two calendar years	
Standard Plastic Lenses or Contact Lenses	Once every calendar year	

*Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's medical director and are subject to change based on market conditions.
*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

Additional purchases and out-of-pocket discount:
Members will receive a 20% discount on remaining balance at Participating Providers beyond plan coverage; the discount does not apply to EyeMed's Providers' professional services or disposable contact lenses. Members also receive a 40% discount off complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used.

Benefits are not provided for services or materials arising from:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
- Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes or supporting structures;
- Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment;
- Safety eyewear;
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- Plano (non-prescription) lenses and/or contact lenses;
- Non-prescription sunglasses;
- Two pair of glasses in lieu of bifocals;
- Services or materials provided by any other group benefit plan providing vision care; Certain brand name Vision Materials in which the manufacturer imposes a no-discount policy; or
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Benefits may not be combined with any discount, promotional offering, or other group benefit plans.

The Plan pays for covered eye exams and corrective lenses once every calendar year. Frames are covered once every other calendar year.

The following definitions may help you better understand the terms commonly used in vision care:

- An **ophthalmologist** is a doctor of medicine specializing in diseases of the eye. An ophthalmologist may perform surgery;
- An **optometrist** is a doctor of optometry who examines eyes for imbalances that can be corrected by prescription lenses; and
- **Lenticular lenses** are lenses that are shaped like magnifying glasses, thick in the middle and thin at the edges.

WHAT THE PLAN DOES NOT COVER

Some of the items that are not covered under the Vision 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 EyeMed Vision Care Customer Service at 1-855-273-4537 prior to receiving the service.

- Special eyeglass lenses or coatings other than as listed under "Lens Options" in the Summary of Benefits above;
- Eye surgery or medical treatment (these may be covered under the Medical Plan);
- Special corrective procedures or aids;
- Expenses for more than one pair of glasses or contact lenses (except disposable contact lenses), unless you have a significant change in prescription or if you now have single vision lenses and bifocals are prescribed;
- Replacement of lost or stolen glasses that are less than two years old;
- Experimental services or supplies;
- Services or supplies that are not medically necessary according to prevailing standards maintained by EyeMed Vision;
- Expenses you incurred before your coverage began; or
- Expenses covered under Workers' Compensation.

COORDINATION OF BENEFITS

Coordination of benefits occurs when you have vision coverage through Dominion Energy and another group vision plan.

Under the Vision Plan's coordination of benefits provision, benefits from this and any other plan are coordinated so that benefits from both plans do not exceed 100% of expenses actually incurred.

If you are enrolled in the Vision Plan as an employee, this Plan is primary and pays benefits first for your expenses. Any other group 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 is covered under the Dominion Energy Vision Plan, it is considered secondary for your spouse or domestic partner and pays benefits second.

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

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

FILING CLAIMS

When you use an EyeMed Vision Care network provider, the provider will verify your eligibility for services and claim forms are not required.

You need to fill out claim forms for out-of-network vision expenses. The *Dominion Energy Vision Care Claim Form* is available by calling the Dominion Energy HelpLine at 1-877-947-4636. Complete a separate claim form for each patient.

To file a claim, complete the employee portion of the form and ask the provider — the ophthalmologist, optometrist, or optician — to complete the appropriate section. To save time and to expedite your payment, complete your part of the form correctly and completely before giving it to the provider. Then send the form directly to the administrator at the address on the form. Payment is made based on the assignment of benefits. Note: if submitting for reimbursement of a refraction, include the words "Refraction Claim" at the top of the page and include documentation the eye exam and refraction occurred on the same day.

It is your responsibility to ensure that claims are filed in a timely manner. EyeMed Vision Care only processes claims it receives within 12 months following the end of the year in which a service was performed.

If EyeMed 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 EyeMed notifies you within that period that there are special circumstances requiring an extension of time of up to 15 additional days.

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.*

Vision Claim Appeals

If a claim is denied in whole or in part, you or your dependent will automatically receive a written notice of the denial explaining:

- The specific reason for the denial;
- The specific Plan provisions on which the denial is based (including, in the case of group health plans and plans providing disability benefits, information on any internal rule, guideline, or other criteria on which the denial of benefits is based and, if the denial is based on medical necessity, experimental treatment, or similar exclusion, an explanation of the scientific or clinical reasons for the determination);

- Any additional information (such as proof of age or spouse's data) required to reconsider the claim and an explanation of why the information is needed; and
- An explanation of the Plan's appeal procedures, including your right to challenge the final determination in federal court.

After your claim is denied, you will have an opportunity to appeal the denial. You must submit your appeal to the Claims Administrator within 180 days after the date you receive the denial letter. Your appeal must be in writing and must include at least the following information:

- Name of Employee;
- Name of the Plan;
- Reference to the initial decision; and
- An explanation why you are appealing the initial determination.

You may also submit other written comments, documents, records or other information relating to your claim.

As part of the appeal process, you will be provided, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. A document, record or other information will be considered relevant if it:

- Was relied upon in denying the claim;
- Was submitted, considered or generated in the course of processing the claim, regardless of whether it was relied upon;
- Demonstrates compliance with the claims procedures process; or
- Constitutes a statement of Plan policy or guidance concerning the denied benefit, regardless of whether it was relied upon.

In reviewing a denied claim, the reviewer will take into consideration all comments, documents, records and other information submitted by you or your dependent in support of the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will notify you in writing of the decision on appeal. If your appeal is denied in whole or in part, you or your dependent will be provided a written notice that provides the same information regarding your claim as the initial denial, as set forth above.

Important: Written complaints or any questions concerning your vision plan, claims, or appeals may be filed with the Claims Administrator at the following address:

EyeMed Vision Care, LLC
Attn: Quality Assurance Department
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-4999

Final Appeal with the Plan Administrator
If all levels of appeal have been exhausted with EyeMed Vision, the Vision 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 EyeMed Vision 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. EyeMed Vision, as the Claims Administrator of the Dominion Energy Vision Plan, reviews and makes all medical determinations after consultation with a qualified medical professional.

You must exhaust your appeal rights with EyeMed Vision 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 EyeMed Vision 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 EyeMed Vision 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 EyeMed Vision. 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 Vision 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.

The Claims Administrator makes and reviews all determinations as to whether vision benefits are payable under the Plan 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 Vision 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
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 and dependent children 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 continues);
- 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 (see Eligibility section for details):
  - Coverage ends for children on the last day of the month during which they attain age 26.

If you die, coverage will continue for your covered dependents 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.

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

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

CHANGING OR TERMINATING THE PLAN

Except as set forth in the following paragraph, no changes affecting benefits provided under the Vision 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 Vision Plan benefits 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 Vision Plan, those official documents will govern.