Dominion Energy Ohio
UWUA Local G555

Medical
Summary Plan Description

INTRODUCTION

To help protect you and your family against a significant impact in the event of injuries and illnesses, Dominion Energy offers you the option to choose from three Medical Plan Options. You may also waive medical coverage. Dominion Energy also offers medical benefits to eligible retirees under the Retiree Health and Welfare Plan, as well as medical coverage for certain disabled employees and survivors of former employees under the Disability and Survivors Medical Plan. These plans are referred to in the Summary Plan Descriptions (SPDs) as the “Medical Plans.”

Benefits described in the 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 medical coverage.

Dependents
You must be enrolled in the medical plan to 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 under applicable law and for whom you can provide proof of marriage such as 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 (i.e., the children of your current legal spouse)) who are under age 26.

- Your **disabled children** age 26 or older, provided:

they became disabled before age 26; and
they qualify as your dependent for tax purposes (i.e. you can claim them as a dependent on your federal income tax return for the year);.* and either
They were already enrolled in the Plan at the time they became disabled;
For a newly-hired employee with a child who is already disabled, they are enrolled immediately upon your employment; or
They lost coverage under another group health plan and are added at Open Enrollment or with a Qualifying Life Event (see below).

For this purpose, “disabled” means permanently and totally disabled by Social Security Administration standards, which generally means that the child is unable to engage in substantial gainful activity 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. Employees may be required from time to time to provide proof of the child’s continuing disability.

- 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 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 them 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
- You + Child(ren) and Domestic Partner

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

When a Dependent is a Dominion Energy Employee
If you and your spouse, Domestic Partner, or other dependent are both employed by Dominion Energy, no one can be covered as both an employee and a dependent. Also, dependent children cannot be covered by more than one employee. When enrolling, you have two options:

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

Rescission of Coverage
Effective January 1, 2011, the plan may not rescind coverage once you are covered under the plan unless you perform an act, practice or omission that constitutes fraud or make an intentional misrepresentation of material fact as prohibited by the terms of the plan. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. If rescission is permitted, the plan must provide you with 30 days advance written notice prior to such rescission.

ENROLLMENT

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

- If you enroll within thirty-one days following your first day of work, coverage starts on your first day of work; or

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

You will be able to enroll electronically in the Medical Plan through Your Benefits Resources (YBR). You can access YBR:

- Directly from HR Home once you've logged on to your work computer.
  - From the HR Home front page, select the "Your Benefits Resources" link under the Health & Benefits tab to link directly to your YBR account via single sign-on. First time users: you 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 each time you access your account. 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 medical 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).

If you enroll a new dependent in the Employee Medical Plan mid-year as a result of a Qualifying Life Event, you will also have the opportunity to select a different medical option (e.g., Medical Option B to Medical Option A), if your new dependent qualifies as a "Special Enrollee." Special Enrollees include new spouses/domestic partners, newborn children, new stepchildren, newly adopted children, and children newly placed with you for adoption.

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 medical 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 (can change medical options at this time) • Enroll self, spouse or domestic partner, newly eligible child and other child(ren)	• Drop deceased child

Event	Enrollments Permitted	Cancellations Permitted
Satisfying or ceasing to satisfy eligibility requirements	• Add newly eligible child and other children (can change medical options at this time)	• Drop newly ineligible child
Qualified Medical Child Support Order	• Add child(ren) required by QMCSO (if you are not enrolled, you will also be enrolled at this time) • 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 • Enroll self and children, if coverage is lost under domestic partner's plan**	• 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 (can change medical options at this time)	• Drop domestic partner who became covered under their employer's plan
Domestic partner's employer no longer contributes to their group medical coverage	• Add domestic partner (can change medical options at this time)	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 medical coverage	• Add spouse, domestic partner or children who lost other coverage (can change medical options at this time) • Enroll self, spouse, domestic partner, or children who lost other coverage	N/A

Event	Enrollments Permitted	Cancellations Permitted
Exhaustion of other employer coverage (including COBRA) or other employer no longer contributes toward other coverage**	• Add spouse, domestic partner or children who lost other coverage or lost employer subsidy (can change medical options at this time) • Enroll self, spouse, domestic partner, or children who lost other coverage or lost employer subsidy	N/A
Entitlement or loss of entitlement to Medicare or Medicaid	• Add spouse, domestic partner or children who lost Medicare/Medicaid (can change medical options at this time) • Enroll self, spouse, domestic partner, or children who lost Medicare/Medicaid	• Drop self, spouse, domestic partner, or children who became entitled to Medicare/Medicaid
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.
Eligibility for premium assistance under the plan through a state children's health insurance program (CHIP)	• Add spouse, domestic partner or children who became eligible for premium assistance (can change medical Options at this time) • Enroll self, spouse, domestic partner and/or children who became eligible for premium assistance	• N/A
Termination of Medicaid or CHIP coverage due to loss of eligibility	• Add spouse, domestic partner or children who lost Medicaid or CHIP coverage (can change medical Options at this time) • Enroll self, spouse, domestic partner and/or children who lost Medicaid or CHIP coverage	• N/A
Spouse events		

Event	Enrollments Permitted	Cancellations Permitted
Marriage	• Add spouse and children, including new stepchildren (can change medical options at this time) • 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 (can change medical options at this time) • 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 (can change medical options at this time) • 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 medical coverage	• Add spouse and children who lost subsidy under spouse's plan (can change medical options at this time) • 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.
**Applies only if you previously declined to enroll in this Plan because you had such other coverage at the time you were eligible to enroll.
***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. I

* 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 all other qualifying life events.

Qualifying Life Event changes take effect as follows:

- Adding coverage – coverage begins on 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 medical 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 medical 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, 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.

The amount of your contributions depends on which Medical Plan Option you select and your coverage level (You Only, You + Child(ren), etc.). Contributions may be adjusted on an annual basis to reflect changes in the cost of coverage.

HOW THE MEDICAL PLAN WORKS

You can choose from three Medical Plan Options listed below.

- Medical Plan Option A*;
- Medical Plan Option B; or
- Medical Plan Option C.

* You cannot enroll in Option A with the HSA if you have other health coverage that pays for medical expenses such as Medicare Part A and/or B, Medicaid, a healthcare flexible spending account (FSA) a health reimbursement arrangement (HRA) or coverage under a spouse's plan, including a healthcare FSA or HRA through your spouse's employer. If you enroll in this Option and have other coverage, you could be subject to penalties.

Options A, B, and C
All three Options are alike in the following:

- Cover the same medical services and supplies, including preventive care coverage;
- Have the same Blue Cross Blue Shield PPO national network of doctors, hospitals and providers; and
- Have Anthem Blue Cross Blue Shield process medical claims.

The Options differ from each other in:

- The deductibles, copayments and out-of-pocket maximums;
- The prescription drug administration and plan designs;
- The contributions deducted from your pay; and
- Pre-tax accounts – Option A has a Health Savings Account (HSA) and Options B and C allow you to enroll in a Healthcare Flexible Spending Account (FSA).

ID Cards

After you enroll, you are sent two medical identification (ID) cards with a unique identifier that is not your social security number. Your ID card signifies that you have coverage under the Medical Plan with the Blue Cross Blue Shield national PPO network. You, your doctor, or the medical facility should always include the information on your ID card when filing claims for benefits.

If you lose your card, or need an additional card, contact Anthem Customer Service at 1-800-348-1966.

PPO Networks

All three Medical Plan Options are administered by Anthem Blue Cross and Blue Shield based in Richmond, Virginia. This provides consistent claims processing and payment throughout Dominion Energy and access to the national Blue Cross Blue Shield Preferred Provider Organization (PPO) network. A PPO network is a group of health care providers who have agreed to accept a negotiated fee as payment for their services. Local networks of Blue Cross Blue Shield doctors, hospitals and other participating providers deliver your care, submit your claims and pre-authorize your hospital admission. PPO networks give you the flexibility to select providers without having to select a primary care physician to coordinate your care. You have the flexibility to go directly to specialists, although it is recommended that you have one physician for overall care.

If you use providers who participate in the PPO network you receive a higher level of benefit. To determine if your doctor and/or hospital is in the network, you can call 1-800-810-BLUE (2583) or check the Anthem Web site at www.anthem.com. Select the National Blue Card Directory, PPO Network.

In an emergency, go to the nearest appropriate provider or medical facility. If the provider or facility is not in the network, you or your network physician can call Anthem as soon as you are able in order to have the out-of-network services authorized for the highest level of benefits, at the plan's in-network cost sharing rate.

If specialty care is required and it is not available from a provider within the network, your network provider can call Anthem in advance of your receiving care and request the out-of-network services be authorized for the highest level of benefits.

Care Outside the United States – Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Anthem to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up-to-date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll-free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact Anthem for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the Health Care Management – Precertification section for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core®
In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance, or deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors' services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core® claim forms you can get international claim forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Network Allowance
Network allowances are established by Blue Cross Blue Shield, and are the fees that PPO providers have agreed to accept as payment-in-full for their services. Network allowances may vary from one geographic area to another.

When you receive in-network services you are not responsible for paying the difference between the network allowance and the provider's charges. Your copayment amount is based on the network allowance. Therefore, the provider's charges that are in excess of the network allowance do not apply to your deductible and out-of-pocket maximums.

When you receive covered services from out-of-network providers, the Plan pays benefits at the network allowance level. You are responsible for paying the provider the difference between the provider's charges and the network allowance, in addition to your copay. The difference between the provider's charges and the network allowance does not apply toward your deductible or out-of-pocket maximum. Please see the section called "Balance Billing" later in this SPD for more information, including certain exceptions to this rule.

Deductible
The medical deductible is the amount of covered expenses you must pay each year before the Plan begins to pay benefits for many covered services. Covered expenses in-network and out-of-network are combined to satisfy the deductible. The amounts you pay toward your medical deductible apply to your medical out-of-pocket maximum. Under all three Options, there is no deductible for in-network preventive care.

- Under **Option A** there is a deductible amount for You Only coverage and a deductible amount for You + Family coverage. You + Family coverage includes all other coverage levels including You + Spouse/Domestic Partner and You + Child(ren). There is no "individual" deductible amount under Option A. If you cover yourself and any other dependents, you must meet the annual family

deductible before the Plan covers any individual family member's expenses (other than preventive care); and

- Under **Options B and C** there is an individual and a family (two or more persons) deductible for covered medical expenses. Each covered family member is subject to the individual deductible until expenses equal to the family deductible have been met. Once the combined deductibles for all covered family members equal the family deductible amount, no further deductible needs to be met for the year. No single family member pays more than their individual deductible in any calendar year. There is a separate deductible for prescription drug coverage under Options B and C. See Summary of Benefits.

Copayments
Under all three Medical Plan Options, once the deductible is satisfied, you and the Plan each pay a percentage of the allowable charges for covered medical care and treatment received either in or out-of-network. Your percentage copayment is based on the lower of the provider's billed charge or the allowable charge.

Copayments for covered services apply to your out-of-pocket maximum.

Out-Of-Pocket Maximum
The amounts you pay towards your deductible and copayments for covered services apply to the out-of-pocket maximum. When you satisfy the medical deductible and the medical maximum copayment amount, you have reached your out-of-pocket maximum. After this point, the Plan pays 100% of allowable charges for covered medical expenses for the rest of the calendar year.

Under all three Options, there is an out-of-pocket maximum amount for You Only coverage. There are individual **and** family out-of-pocket maximum amounts for You + Family coverage. You + Family coverage includes all other coverage levels including You + Spouse/Domestic Partner and You + Child(ren). Each covered family member is subject to the individual out-of-pocket maximum amount until expenses equal to the family out-of-pocket maximum amount have been met. Once the combined out-of-pocket expenses for all covered family members equal the family out-of-pocket maximum amount, no further copays need to be paid during the year. No single family member pays more than their individual out-of-pocket maximum amount in any calendar year. A separate out-of-pocket maximum applies to prescription drugs under Options B and C (see the Summary of Benefits table).

The out-of-pocket maximums for in-network and out-of-network expenses cross-accumulate. This means that covered expenses apply to both in and out-of-network out-of-pocket maximums.

Indexing
The deductibles and out-of-pocket maximums for both the medical and prescription drug benefits are adjusted each year based on the increase in the Medical Consumer Price Index. Increases will not exceed 5% per year.

Lifetime Maximum Benefit
There is no lifetime dollar limit under any of the three Options.

Summary of Benefits
This chart compares the key features of the Medical Plan Options. The deductibles and out-of-pocket maximums are indexed as of 2023:

	Option A		Option B		Option C	
Plan Features	In-network	Out-of-Network	In-network	Out-of-network	In-network	Out-of-network
Annual medical deductible: • Employee only coverage • Employee and dependent coverage (including domestic partners) - Per person - Per family	$2,100 N/A* $4,200*		$1,190 $1,190 $2,380		$590 $590 $1,180	
Copayment (what you pay after the deductible for most covered care): • Medical care and services, including mental health and chiropractic** • Office visits, including mental health and chiropractic** (See Preventive Care section) • LiveHealth Online (covered only where consultation / prescription is allowed)	20% 20% 20%	40% 40% 40%	20% 20% 20%	40% 40% 40%	20% 20% 20%	40% 40% 40%
Emergency Room Copayment • Copayment waived if admitted to hospital	20%	40%	$100 then deductible and 20%	$100 then deductible and 40%	$100 then deductible and 20%	$100 then deductible and 40%
Annual medical out-of-pocket maximums:*** • Employee only coverage • Employee and dependent coverage (including domestic partners) - Per person - Per family	$4,920 $7,000* 9,840*	$9,830 $14,0000* $19,660*	$4,750 $4,750 $9,500	$8,310 $8,310 $16,620	$2,380 $2,380 $4,760	$4,160 $4,160 $8,320

	Option A		Option B		Option C	
Plan Features	In-network	Out-of-Network	In-network	Out-of-network	In-network	Out-of-network
Prescription Drug coverage:	*Administered by Anthem and Express Scripts* • Includes retail and home delivery • After you meet your medical deductible, you will pay 20% for covered prescriptions • After you reach the medical out-of-pocket maximum, the Plan reimburses you 100% for covered prescriptions for the rest of the calendar year • All specialty drugs must be filled by Accredo, Express Scripts' specialty drug pharmacy, after one fill at a retail pharmacy. Specialty drugs are dispensed for up to a 30-day supply.		*Administered by Express Scripts* • After you meet $84 per person annual prescription deductible, you pay: **At a retail pharmacy for up to 30-day supply** Generic 20%, $5 minimum Formulary brand 25%, $20 minimum Non-formulary brand 35%, $35 minimum **Through home delivery for up to a 90-day supply** Generic 20%, $10 minimum Formulary brand 25%, $40 minimum Non-formulary brand 35%, $70 minimum • After your covered out-of-pocket costs reach the $1,050 annual per person prescription drug out-of-pocket maximum, the Plan pays 100% of that person's covered prescription costs for rest of calendar year. • All specialty drugs are filled by Accredo. Specialty drugs are dispensed for up to a 30-day supply and are subject to retail copayment.		
Employee contribution rate:	Lowest contribution rate → Highest contribution rate					
Health Savings Account (HSA) available	Yes – funded by automatic Dominion Energy contributions and additional voluntary pre-tax contributions from you		No			
Healthcare FSA available	No		Yes – funded by voluntary pre-tax contributions from you			
Lifetime maximum benefit	No lifetime dollar limit					

*If you select Option A and enroll your dependents, you must meet the ***Family*** deductible before any expenses are paid for services other than covered preventive care. If an individual meets the $7,000 out-of-pocket maximum, the plan pays 100% for that individual. Other family members will need to meet the remaining portion of the family out-of-pocket maximum of $9,8408before the plan pays 100% for all family members.

**Chiropractic is a maximum benefit of 20 visits per person per year.

***Your actual financial responsibility for medical expenses could be greater than the annual out-of-pocket maximum. Non-covered services, out-of-network provider charges above the plan allowance, and amounts above plan limits do not apply to the out-of-pocket maximum, and you will always be responsible for these expenses, regardless of whether you have met your out-of-pocket maximum.

Deductibles and out-of-pocket maximums are updated each plan year. You will be notified of each plan year's deductibles and out-of-pocket maximums during open enrollment, which takes place before the plan year begins.

Preventive Care
Preventive care is an important part of keeping you and your family healthy and helping Dominion Energy to control future benefits costs. All three Medical Plan Options offer the same preventive care benefits – with no copayment and without having to meet the deductible – as long as you use a network provider.

Covered vaccines may be purchased in- or out-of-network under both Anthem and Express Scripts. Out-of-network preventive care is not covered under the plan.

Preventive care benefits for children through age 6 include routine care, screenings, checkups, and immunizations – based on recommendations of the American Academy of Pediatrics. For detail see Covered Services section, "Preventive Services."

Preventive care services ages 7 and older include:

Service	Copayment	Comments
• Annual checkup office visit; • Annual gynecological exam and Pap test; and • Annual prostate exam and PSA test for men • Annual mammogram* • Annual colorectal cancer screening* • Routine tests, lab and x-ray services associated with an annual check-up, gynecological or prostate exam.	$0	
Immunizations	$0	Covers immunizations to prevent or reduce the risk of conditions such as tetanus, flu and human papillomavirus (HPV). Some immunizations may require prior approval. Covered immunizations may be purchased in or out-of-network under both Anthem and Express Scripts. *Note: all out-of-network claims must be filed with Anthem*.
• Women's contraceptives, sterilization procedures, and counseling. Coverage	$0	

includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. • Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy. • Gestational diabetes screening.		

*The Plan pays for one mammogram and colorectal screening each calendar year, even if your doctor determines there is a medical condition.

> *Note: If you are uncertain as to whether a particular service is covered under the Plan's preventive care program, confirm with Anthem Customer Service at 1-800-348-1966 prior to having the service performed.*

In addition, all three Options cover the preventive care benefits required by the Affordable Care Act. You do not pay any out-of-pocket costs for these preventive care benefits when you use an in-network provider. You can obtain more information about your preventive care benefits under the Affordable Care Act by visiting www.healthcare.gov. The plans interpret and apply the list of covered preventive care services consistent with the Affordable Care Act, including recognizing changes to this list as required by law. Please note that, consistent with the Affordable Care Act, this paragraph does not apply to retiree medical plan coverage.

PRESCRIPTION DRUGS

Prescription drugs are medicines that require a prescription order from your doctor. These are also known as legend drugs, or drugs which federal law stipulates can only be obtained with a prescription.

The Plan covers eligible *prescription drugs* if received through a pharmacy, a doctor's office, or a hospital. Prescriptions filled at a licensed pharmacy are covered under the prescription drug portion of the plan through Express Scripts. Any prescription drugs that you receive from your doctor's office or at a hospital are considered for coverage in the same manner as other medical services or supplies.

Generic and Brand Name Drugs
The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, strength, and effectiveness. Using generics saves money, yet provides the same quality.

- If the prescription is for a generic drug, the generic drug is dispensed and you are responsible for any deductible and coinsurance amount. The Prescription Drug Program covers allowable charges up to the cost of the drug;
- If the prescription is for a brand-name drug and a generic equivalent exists, and the doctor indicates substitution of the drug is permissible on the prescription form, the prescription is automatically filled with a generic drug. (If a generic equivalent does not exist, the brand-name drug is dispensed.) You are responsible for any deductible and coinsurance amount. The Prescription Drug Program covers allowable charges up to the cost of the drug.
- If the prescription is for a brand-name drug* and a generic equivalent exists, and your doctor requests the brand-name drug (by indicating "dispense as written" or "brand necessary" on the prescription form), the brand-name drug is dispensed. You are responsible for any deductible and

coinsurance amount. The Prescription Drug Program covers allowable charges up to the cost of the drug.

- If the prescription is for a brand-name drug* and a generic equivalent exists, and your physician has not directed "dispense as written" or "brand necessary" on the prescription form, and **you** (not the doctor) request the brand-name drug instead of the generic drug, **you** are responsible for an additional fee, which is the difference in cost between the generic and brand name drug. This fee is in addition to any deductible and coinsurance amount for the brand name drug. The Plan covers allowable charges for the generic drug only. The difference in cost between the generic and brand-name drug is an additional cost to you and is also known as an "ancillary fee."

  **Please remember that if the brand-name drug your doctor prescribed is subject to step therapy, the Plan will not cover the prescribed drug until you satisfy the step therapy requirements.*

Copayments

- **Option A:** After you meet your medical deductible, you pay 20% for covered prescriptions;
- **Options B and C**: After you meet the per person annual prescription deductible:
  - If the total cost of the drug is under the minimum dollar amount, you pay the total cost of the drug;
  - If the coinsurance percentage amount is under the minimum dollar amount, you pay the minimum; and
  - If the coinsurance percentage amount is higher than the minimum dollar amount, you pay the percentage amount.

ID Cards

- **Option A**: Your prescription ID card is the same as your medical ID card; and
- **Options B and C**: You receive a separate ID card from Express Scripts.

Prior Authorization, Quantity Limits and Step Therapy

The Plan requires prior review and approval of certain medications and/or quantities of medications before payment is authorized. Other medications may be subject to the step therapy program. Medications that require prior authorization, quantity limits and step therapy are modified periodically.

- To find out if the medication you are taking has a prior authorization, quantity limitation or step therapy requirement contact Express Scripts at 866-282-0547 or visit their web site at www.express-scripts.com. The most effective way to initiate a prior authorization review is to ask your physician to contact Express Scripts' Prior Authorization hotline at 800-417-8164. If your request is approved, your doctor is notified and an approval code is provided to the pharmacist for the claim to be processed. You must follow-up with your doctor to see if approval was received. If approval was received, the next step is to contact the pharmacist so that the prescription can be processed. If the request is not approved, your doctor is notified during the call, and a follow-up letter is sent to you and your doctor. If your doctor wishes to complete a Prior Authorization form instead of calling Express Scripts, the form can be obtained by calling Express Scripts at 866-282-0547 or by visiting the Express Scripts web site at www.express-scripts.com. After the form has been completed, it can be faxed to Express Scripts at 800-357-9577 or mailed to:

  Express Scripts
  6625 W. 78th Street
  BL0345
  Bloomington, MN 55439

  Express Scripts notifies your doctor of the approval or denial within 48 hours of receipt of the prior authorization form.

Network Pharmacies
Network pharmacies are available nationwide and automatically file your claim for you. Just show your ID card to receive benefits. To obtain a refill you must have used 75% of your prescription.

- You may receive up to a 90-day supply (60-day supply under Option A) of medicine at a CVS pharmacy for an original prescription and refills for up to one year. To find other pharmacies that participate in the Express Scripts Pharmacy Network ask your local pharmacy if they participate or call Express Scripts at 866-282-0547 or visit their website at www.express-scripts.com.

Out-of-Network Pharmacies
You may use pharmacies outside the network, but if you do, you must:

1) pay for the prescription at the time it is dispensed, and
2) file a claim with Express Scripts.

The plan will pay the allowable charge after your deductible and copayment. You will be responsible for the difference between the billed amount and the allowable charge.

Home Delivery Program
In addition to receiving your medication at Network Pharmacies, you may also purchase your maintenance medication through the home delivery program. Ask your doctor to prescribe a 90-day supply of your maintenance medicine plus refills for up to one year. If you need the medicine immediately, ask your doctor for two prescriptions: one to be filled right away at a local network pharmacy and another to send to the home delivery pharmacy. Mail your original prescription(s), the completed home delivery form and a check to cover the amount of your coinsurance payment(s). You may charge your coinsurance payment with a major credit card by completing the needed information on the home delivery form.

You receive your prescription drugs via first class mail or other common carrier approximately 14 days from the date your order is received. You receive refill forms and a notice that shows the number of refills your doctor ordered in the package with your medication. To order refills, you must have used 60% of your prescription.

- Mail your order form to:

  Express Scripts Mail Pharmacy Service
  P.O. Box 1146
  Bensalem, PA 19020-1146

You may also request refills and reimbursement forms by calling Express Scripts at 866-282-0547 or by visiting their website at www.express-scripts.com.

Filing Claims
You may need to file your own claim if you have a prescription filled before you receive your card, if your prescription is filled at an out-of-network pharmacy, or if you have a prescription that requires special prior approval but you need the prescription filled immediately. You must pay for the prescription and file for reimbursement.

Contact Express Scripts if you need a prescription drug reimbursement form. You can also print a copy of the form from the Express Scripts website at www.express-scripts.com. To file a claim, follow these 3 steps:

1.) Pay for the prescription;
2.) Complete the prescription drug reimbursement form; and

3.) Mail your claim form to the address on the form.

Maintenance Drugs
Prescriptions for maintenance drugs may be filled at a retail pharmacy or can be filled through the Home Delivery program. A maintenance drug is a prescription medication that is taken on an ongoing basis and is prescribed by your physician in minimum quantities of a 30-day supply. A few examples of maintenance drugs are those for high blood pressure, arthritis, asthma, high cholesterol or diabetes. To have a maintenance prescription filled, ask the doctor for a written prescription for a 90-day supply, plus refills, if appropriate. It is important that the doctor write the prescription for a 90-day supply plus refills, because by law, Express Scripts can only dispense the exact quantity prescribed by the doctor.

Formulary
A formulary is a preferred list of FDA-approved prescription drugs and supplies developed by Express Scripts' Pharmacy and Therapeutics Committee. The Committee is an independent group of pharmacists and physicians from a broad range of medical specialties. Drugs and supplies are included in the formulary based primarily on their clinical effectiveness and secondly on cost-effectiveness. Formulary drugs are used as a guide for determining the amount of your copayment for each prescription, with drugs on the formulary typically available at a lower copayment. Your doctor can use this list to choose medications for you while helping you save money. Drugs on the formulary can be purchased from local retail pharmacies or through the Express Scripts Home Delivery Pharmacy. You can find out if your medication is on the formulary by calling Express Scripts at 866-282-0547 or by visiting their website at www.express-scripts.com.

Specialty Drugs
Specialty drugs are complex and costly medications for specific conditions such as multiple sclerosis, rheumatoid arthritis, blood disorders and hepatitis C. They usually require special storage and handling and may not be readily available at your local retail pharmacy. Specialty drugs must be filled through Accredo, Express Scripts' specialty drug pharmacy, except that under Option A you may obtain your initial fill at a retail pharmacy. If the prescription you fill at a retail pharmacy is a specialty medication, you and your doctor will receive a letter from Express Scripts. It will provide information so that future refills can be dispensed by Accredo. Under Options B and C, all specialty drugs must be filled through Accredo starting with the first fill, except that certain emergency specialty drugs (as determined by Express Scripts) may be filled at a retail pharmacy for the first 2 fills and then must be filled at Accredo thereafter. Specialty drugs are dispensed for up to a 30-day supply and are subject to the retail copayment.

In addition, if you participate in Option B or C, certain specialty drugs qualify for a program called SaveOnSP. By taking advantage of copay assistance available from the pharmaceutical manufacturers, the SaveOnSP program allows you to receive your specialty drug with **zero ($0) out-of-pocket cost.**

You must enroll in the SaveOnSP program prior to your first fill to take advantage of this opportunity. If your specialty drug is on the SaveOnSP list, and you do not enroll in the program, you will be responsible for the full copayment for that drug. These drugs are considered non-essential health benefits under the Affordable Care Act, often have higher copayments than other prescription drugs, and will not count toward your deductible or out-of-pocket maximum limits. If you are prescribed a specialty drug on the SaveOnSP list (which is determined by SaveOnSP and is subject to change at any time), you can expect to hear directly from SaveOnSP about enrollment in the program. You also may contact SaveOnSP at 1-800-683-1074 for more information on the program, including the current list of specialty drugs and their copayments.

OPTION A – HEALTH SAVINGS ACCOUNT (HSA)

Option A has the lowest contribution rate and the highest deductible and out-of-pocket maximum of all the Medical Plan Options. It also comes with a Health Savings Account (HSA).

You can use the money in your HSA for:

- Expenses you incur while meeting your deductible;
- Medical and prescription drug copayments;
- Other healthcare expenses, such as dental and vision expenses not paid by any plan but allowed by the IRS; or
- A way to save for future healthcare expenses, by letting contributions add up to cover future healthcare costs next year or longer-term.

Additional information on HSAs may be found in Publication 969 on the IRS website, www.irs.gov.

A Health Savings Account (HSA) is like a personal savings account for healthcare, except it's all tax-free. If you enroll in Option A:

- Dominion Energy makes a tax-free contribution to your HSA by January 31st. You may add your own pre-tax contributions. You decide how much you want to contribute from your pre-tax pay. Note: You must have a $0 balance in your Healthcare Flexible Spending Account (FSA) on December 31 in order to get the Dominion Energy Health Savings Account (HSA) contribution in January or start making your own HSA contributions in January. Otherwise, due to Internal Revenue Service (IRS) rules, all contributions (yours and Dominion Energy's full annual contribution) will be delayed until your 1st pay period in April.
- You may change your contribution amount during the year with changes effective the first of the month after you contact the Dominion Energy Benefit Center at 1-877-434-6996.
- When you enroll in Option A, your information will automatically be sent to HSA Bank to open your account. If HSA Bank requires additional information in order to activate your account, they will contact you directly. If you fail to respond within their time allowed, your account will be closed and any contributions you have made will be returned to you in a check from HSA Bank. If your account is closed, any future attempts to open an HSA will require a manual form to be submitted to the bank.
- Account balances earn interest. You can invest in mutual funds through HSA Bank. Contact HSA Bank directly at 1-800-357-6246 for details.
- There are some fees associated with your HSA account. Dominion Energy pays the one-time set-up fee to open your HSA and the monthly maintenance fee. You are responsible for all other fees charged by HSA Bank including, but not limited to: fees related to withdrawing money through an ATM, writing checks from your HSA and transfer/termination or rollover fees. If you decide to move out of Option A and elect coverage in Option B or C, Dominion Energy will no longer pay the monthly maintenance fee. This fee will only be covered by Dominion Energy while you are enrolled in Option A. Additionally, using your HSA debit card for ATM withdrawals or at point of sale with your PIN results in a $2.00 fee per usage. The $2.00 fee charged at point of sale can be avoided by selecting "Credit" instead of "Debit" when you swipe your card. There is also a $2.00 investment fee unless you elect to receive electronic account statements.
- You manage the money in your account and decide how to use it. You may use the dollars in your HSA to pay your eligible out-of-pocket healthcare costs tax-free. For example, this includes medical expenses before you meet your deductible, medical copayments or other eligible out-of-pocket healthcare costs for vision and dental care.
- You are responsible for making sure you use the HSA for eligible expenses and can provide proof of those expenses if the IRS requests them. It's important to make sure to save copies of receipts for expenses paid through your HSA.

Coverage tier	Dominion Energy contributions	You can add up to	Total contribution (from Dominion Energy and you)
You Only or You + Domestic Partner coverage	$500 per year	Up to $3,350 per year	Up to $3,850per year
You and any dependent coverage	$1,000 per year	Up to $6,750 per year	Up to $7,750 per year

In addition to the limits shown in the chart above (applicable for 2023), participants who are between the ages of 55 and 65 (and not enrolled in Medicare) are permitted to contribute additional "catch-up" contributions to their HSA. Those individuals may contribute up to an additional $1,000 in 2023. These maximum contribution amounts are subject to change in accordance with IRS rules.

The HSA has some added features:

- No "use it or lose it" to worry about. Unlike the Healthcare FSA, if you don't use all the money in your HSA by year-end, you may carry it forward to the following year. You may also use future years contributions to cover this year's expenses. For example, if you have $1,200 in your account and $1,500 in expenses this year and choose to participate in Option A again next year, you could use next year's account to reimburse yourself for the $300 this year's account did not cover;
- Account balance "carry forward" allows you to save for future healthcare expenses. You can even take the account into retirement to pay retiree healthcare costs;
- Even if you change medical options in the future, you can still use the money in your HSA. You may contribute to the HSA only while you're in Option A, but you can use it to cover eligible healthcare expenses later even if you are enrolled in another Medical Plan Option;
- You can take the HSA with you if you leave Dominion Energy, and draw on it as needed to cover eligible healthcare expenses, or roll your HSA balance into another HSA. If you leave your HSA at HSA Bank, fees are subject to change;
- Unlike an FSA, you may change your HSA individual contribution anytime during the year. To make a change to your HSA contribution, you must contact the Dominion Energy Benefit Center at 1-877-434-6996. Changes are effective the first of the month following the change. Keep in mind, you cannot change your annual contribution amount to be less than what you have already contributed;
- You cannot use the HSA for domestic partner expenses, unless your domestic partner also qualifies as your tax dependent;
- If you enroll in Option A, because of government rules that apply to Health Savings Accounts (HSA), you may not participate in a Healthcare FSA; and
- You may also withdraw money for other reasons, but taxes and penalties may apply.

IMPORTANT NOTE: DO NOT OPEN AN HSA IF YOU HAVE OTHER HEALTH COVERAGE. *You generally are not eligible to make or receive HSA contributions if you have other health coverage that pays for medical expenses such as Medicare, Medicaid, Tricare, a healthcare flexible spending account (FSA), a health reimbursement arrangement (HRA), coverage under a spouse's plan including an FSA or HRA through your spouse's employer, or certain Veteran's Administration healthcare benefits. If you make or receive contributions to an HSA while you have other health coverage, you could be subject to IRS penalties. To avoid these penalties, you should not open an HSA under Option A while you have other health coverage.*

Special Rule - Mid-Year Changes in Other Health Coverage: You are eligible to make or receive HSA contributions only for the months during which you do not have other health coverage. If you

become covered by another health plan in the middle of the year, your maximum annual HSA contribution will be prorated for the number of months during which you were eligible. For example, if you became covered by Medicare on June 15th, you would be deemed HSA-eligible for only five months of the year, and therefore your maximum annual HSA contributions (including yours and Dominion Energy's) would be limited to 5/12 of $7,750 (or, approximately $3,229) for family coverage for 2023. If you find that you have exceeded this limit, you should request a distribution of the excess (including any investment earnings) from HSA Bank before April 15th of the following year to avoid a 6% excise tax on the excess contribution.

Special Rule - Switching to Option A for Next Year: Special IRS rules apply if you had a healthcare FSA in one year and sign up for a health savings account (HSA) under Medical Plan Option A in the subsequent year. In that case, your HSA cannot receive contributions until your healthcare FSA grace period has expired, *unless you had a zero balance in your healthcare FSA as of December 31*. As a result, HSA contributions (yours and Dominion Energy's) will be delayed until April, if your healthcare FSA has a balance as of December 31. To avoid this delay, file healthcare FSA claims well in advance of December 31st.

COMPARING THE MEDICAL PLAN OPTIONS

The three Options cover all the same types of medical care --- including the same preventive care benefits --- and they use the same national Blue Cross Blue Shield PPO network. There are five key differences to keep in mind. Dollar amounts shown in the chart below are indexed as of 2023.

	Option A	**Options B and C**
Who can enroll?	Any eligible employee and eligible dependents. But you cannot receive any HSA contributions (yours or Dominion Energy's) if you have other health coverage that pays for your medical expenses, for example through a spouse's employer, because of IRS rules related to Option A's HSA. See the "Important Note" above under "Option A – Health Savings Account (HSA)."	Any eligible employee and eligible dependents.
Deductibles	If you cover yourself and any dependents, you must meet the annual *family* deductible before the Plan covers any individual family member's expenses. Both medical and prescription drug expenses apply to the deductible.	There are individual and family annual deductibles. The Plan begins to pay expenses for an individual when: They meet the individual deductible; or The family's combined expenses meet the family deductible.
Out-of-pocket maximum	There are individual and family annual out-of-pocket maximums. The plan begins to pay covered expenses at 100% for an individual when: ▪ They meet the individual out-of-pocket maximum; or The family's combined expenses meet the family out-of-pocket maximum.	There are individual and family annual maximum out-of-pockets. The Plan begins to pay covered expenses at 100% when: They meet the individual maximum out-of-pocket; or The family's combined expenses meet the family maximum out-of-pocket.

	Option A	Options B and C
Prescription drugs	• Administered by Anthem and Express Scripts; • Covered after you meet annual deductible -- $2,100 if you have You Only coverage or $4,200 if you cover yourself and dependents; • Both medical and prescription drug expenses apply toward your annual deductible; • Copayment percentages are the same for all types of drugs; and • After out-of-pocket medical maximum is reached, the Plan pays 100% of person's covered drugs for rest of calendar year.	• Administered by Express Scripts; • Covered after you meet the annual prescription drug deductible of $84 per person; • Copayment percentages based on type of drug: generic, formulary or non-formulary; and • After $1,050 per person out-of-pocket prescription drug maximum, the Plan pays 100% of person's covered drugs for rest of calendar year.
Tax-free accounts for healthcare expenses	Health Savings Account (HSA) --- administered by HSA Bank: • Automatic Dominion Energy contribution and opportunity to contribute yourself – for combined contribution up to: - $3,850 a year if you have You Only coverage; or - $7,750 a year if you cover yourself and dependents. • You decide how much to contribute and you may change your contribution amount during the year; • Unused dollars can be carried forward year-to-year; • If you leave Dominion Energy, you may take your HSA balance with you; and • You may pay eligible expenses using an HSA debit card, up to the amount in your account at any point in time.	Healthcare Flexible Spending Account --- administered by PayFlex: • No Dominion Energy contribution; • You have the opportunity to contribute up to $2,850 each year; • You decide how much to contribute during Open Enrollment; • You lose any contributions not used for eligible healthcare expenses during calendar year; • If you leave Dominion Energy, you may use your remaining FSA account balance: - For services that occurred while you were at Dominion Energy; - For services the rest of the calendar year by continuing your FSA coverage through COBRA; and • You pay eligible expenses then submit a claim for reimbursement, up to your annual contribution amount, regardless of what's in your account at the time. You may also sign up for automatic claim submission through PayFlex.

CONDITION MANAGEMENT

Dominion Energy offers a Condition Management program through Anthem's MyHealth Advantage to employees and their dependents enrolled in any of the three Options. This program is free and assists in managing medical conditions, medications, routine tests and check-ups, even reviewing your health status and what medications you are currently taking. MyHealth Advantage provides participants with a personalized summary containing suggestions to help manage existing health conditions, improve overall health, and avoid potential health issues. Anthem will contact you if you meet program criteria.

NURSELINE

As a participant in the Medical Plan, you have access to Anthem's 24/7 NurseLine. You can call the 24/7 NurseLine any time to speak with a registered nurse who is trained to help you make informed decisions about your health situation. Or, if you prefer, you can call and listen to confidential recorded messages about hundreds of health topics by accessing the AudioHealth Library. You may contact the 24/7 NurseLine at 1-866-545-3507.

TELADOC

If you or a family member are diagnosed with a serious health condition or your doctor recommends a complex or expensive medical treatment, Teladoc can provide you with an expert second opinion. When you contact Teladoc, an expert specializing in your condition will check the accuracy of your diagnosis and make recommendations. Teladoc can compile your medical records for you into an easy to use USB and help you find the "Teladoc" in your area in the field you are looking for. Contact Teladoc at Teladoc.com/medical-experts or call 1-800-TELADOC (835-2362).

Oncology Insight, another feature of Teladoc, expands second opinion services by providing access to advanced cancer research powered by IBM Watson technology.
If you have been taken to the hospital in an emergency situation, either you or a family member can call the Teladoc Critical Care line (1-866-237-3286) to have Teladoc involved right away.

HEALTH PRO

Contact your personal Health Pro for a personal guide to all things related to your health benefits. The Health Pro is here to support you and provide you with resources for a simpler, more beneficial health care experience.

They can help you and your family:

- **Understand your benefits** – Clear up any confusion about your health plan.
- **Find great doctors** – Locate highly-rated doctors, dentists, and eye care professionals.
- **Save money on health care** – Compare prices and choose more cost-effective options.
- **Pay less for prescriptions** – Get recommendations for lower-cost medications.
- **Schedule appointments** – Have your appointments scheduled at times most convenient for you.

Contact your Health Pro by emailing DominionEnergyHealthPro@alight.com or calling 866-217-6257 or by logging into Your Benefits Resources (YBR) and clicking on the Connect with your Alight Health Pro tile.

ANTHEM BLUE DISTINCTION CENTERS OF EXCELLENCE (BDC) AND BLUE DISTINCTION CENTERS PLUS (BDC+)

Anthem's BDC/BDC+ program is a referral program that directs you to medical facilities proven to provide excellent care specifically for these conditions:

- Inpatient knee and hip replacements
- Spinal surgery
- Organ transplants

These medical facilities have a track record of better outcomes and faster recovery times. Plus, you may qualify for a reduced copay if you use a BDC/BDC+ facility. Contact Anthem Customer Service at 1-800-348-1966 to find a facility in your area that qualifies for the BDC/BDC+ incentive.

LIVEHEALTH ONLINE

Anthem's LiveHealth Online is a video chat service that puts you in touch with a doctor for non-emergency care when you can't see your regular doctor. All LiveHealth Online doctor visits are covered by your Dominion Energy health plan and applied toward your deductible. Once you reach your deductible, the visit is covered at the copayment level on your plan.

Here's how it works:

- Sign up: Go to www.livehealthonline.com and provide your name, e-mail address and a password. Then answer a couple questions.
- Choose a doctor: On the "See a Doctor Now" page, you'll see information about the board-certified doctors who serve your location. Details about each doctor on the list are provided. You choose the doctor you prefer.
- Start a session: From the "See a Doctor Now" page, click the green "Connect" button beside the doctor of your choice. If that doctor is seeing another patient, you can wait or choose another doctor from the list.

LiveHealth Online Psychology works the same way as LiveHealth Online and allows you to talk with a licensed psychologist or therapist online. Visits start at $80 until you reach your deductible and then they are covered at the copayment level on your plan.

To use LiveHealth Online Psychology, log in to www.livehealthonline.com and select "LiveHealth Online Psychology". Then choose a psychologist or therapist. Generally, you can see a therapist within four days. You must be at least 18 years old to see a therapist online.

WHAT THE PLAN COVERS

The Medical Plan covers a wide range of medical treatments and services. All three Medical Plan Options cover the same medical services. Only those medical services that are medically necessary are covered. To be considered medically necessary, a service must be:

- Required to identify or treat an illness, injury, or pregnancy-related condition;
- Consistent with the symptoms or diagnosis and treatment of your condition;
- In accordance with standards of generally accepted medical practice; and
- The most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family or the provider.

Just because a service is prescribed by a provider does not mean the service is medically necessary. The Plan also requires that services be safely performed in the least costly setting.

See the **Summary of Benefits** table for payment levels and limits for the covered services.

Ambulance travel: Professional ambulance services to or from the nearest facility or provider adequate to treat your condition. Ambulance services billed through the facility are covered the same as all other facility services. Air ambulance services are also covered when pre-authorized or in cases of threatened loss of life. In determining whether any ambulance services will be pre-authorized, Anthem takes into account whether appropriate, cost-effective care is being provided at the facility where the covered person is located.

Applied Behavioral Health (ABA Therapy): treatment for Autism Spectrum Disorder (ASD). Services will be covered in and out-of-network, subject to Anthem's clinical review process and guidelines. ABA benefits must be pre authorized and coordinated through Anthem's Autism Spectrum Disorders (ASD) Program.

Clinical trials for cancer: Treatment for cancer during a Phase I, Phase II, Phase III or Phase IV clinical trial if:

- There is no clearly superior, non-investigational treatment alternative;
- The available clinical or preclinical data provides a reasonable expectation that the treatment is at least as effective as the non-investigational alternative;
- The patient and the provider conclude that participation in the trial is appropriate for the patient;
- The clinical trial is approved by National Cancer Institute (NCI), an NCI cooperative group or an NCI center, the FDA in the form of an investigation new drug application, the Department of Veterans Affairs or an institutional review board of an institution that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI; and
- The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.

Exclusions are non-healthcare services, costs associated with managing the research associated with the clinical trial, and the cost of the investigational drug or device.

Contraceptive devices: Drugs and devices prescribed and supplied through your physician are covered under the Medical Plan. Contraceptive drugs and devices prescribed by your physician and obtained from the pharmacy are covered under the prescription drug benefit.

Dental services: Medically necessary dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem. Also, the cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth; the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face; dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; dental services to prepare the mouth for radiation therapy to treat head and neck cancer; covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when determined by a licensed dentist, in consultation with the covered person's treating physician that such services are required to effectively and safely provide dental care. Information about coverage for impacted wisdom teeth can be found under Surgery.

Diabetic supplies, equipment and education: Medical supplies, equipment and education for diabetes care for all diabetics. This includes insulin pumps; home blood glucose monitors; lancets; blood glucose test strips; syringes, hypodermic needles and syringes. Diabetic supplies are covered under the prescription drug benefit. Also covered is: Outpatient self-management training and education performed in-person, including medical nutrition therapy, when provided by a certified, registered or licensed health

care professional. Diabetic education may be received from pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service.

Diagnostic tests: The following procedures when ordered by your doctor to diagnose a definite condition or disease because of specific signs and/or symptoms: radiology (including mammograms), ultrasound or nuclear medicine; laboratory and pathology services or tests; and diagnostic EKGs, EEGs, and advanced diagnostic imaging services. Observation, diagnostic examinations, or diagnostic laboratory testing that involves a hospital stay is covered under the Medical Plan only when: your medical condition requires that medical skills be constantly available; your medical condition requires that medical supervision by your doctor is constantly available; or diagnostic services and equipment are available only as an inpatient.

Dialysis: Dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis.

Doctor visits and services: Visits to a doctor's office or your doctor's visits to your home; visits to an urgent care center; visits to a hospital outpatient department or emergency room; visits for shots needed for treatment (for example, allergy shots).

Early intervention services: The following services up to a maximum of $5,000 per calendar year for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMH) as eligible under part C of the Individuals with Disabilities Education Act: speech and language therapy; occupational therapy; physical therapy; and assistive technology services and devices. Services must be determined to be medically necessary by DMH and designed to help attain or retain the capability to function age-appropriately within the child's environment, including services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not medically necessary.

Emergency room care: Emergency room visits, services, and supplies necessary for the emergency treatment of traumatic bodily injuries resulting from an accident or a sudden onset of a severe emergency medical condition. Examples of these conditions include: heart attacks, strokes, convulsions, poisonings, loss of consciousness, excessive bleeding, severe asthma attacks, and other severe medical conditions that show acute symptoms and require immediate attention.

Emergency room visits under Options B and C are subject to a $100 copay. The $100 copay is waived if you are admitted to the hospital as a result of the emergency room visit. "Admitted" means you have incurred a room and board charge by the emergency room facility as a direct outcome of your emergency room visit. The hospital/facility determines if your ER visit is charged as inpatient or outpatient.

If you have met the medical plan's deductible, the copay is included in any out-of-pocket charges you must pay for the emergency room visit. If you have not yet met your medical plan's deductible, you must pay the $100 in addition to any charges you incur.

If you are admitted to the hospital from the emergency room, the hospital stays must be reviewed by Anthem within 48 hours of admission or on the next business day. The emergency room doctor, a relative, or a friend can call Anthem for hospital admission review in an emergency. For more information, see the "Hospital Admission Review" in this section.

Gender Reassignment Surgery: Provides gender reassignment surgery and the following services for the purpose of medically necessary gender transition (also known as sex reassignment) for employees and covered dependents diagnosed with Gender Dysphoria:

- Mental health counseling;
- Pharmacy benefits;

- Medical visits and lab procedure; and
- Non-cosmetic surgical procedures, subject to any maximums in the Schedule of Benefits.

Gender reassignment surgery must be approved by Anthem for the type of surgery requested and must be authorized prior to being performed. Charges for services that are not authorized for the surgery requested will not be considered covered services.

For more information, refer to Anthem Blue Cross and Blue Shield's Clinical Policy Bulletin: *Gender Reassignment Surgery*. Clinical Policy Bulletins can be found at https://www.anthem.com/dam/medpolicies/abcbs_va/active/guidelines/gl_pw_a051166.html.

Hearing Aids: Covers hearing aids up to a maximum allowance of $2,500 every 36 months. There is no limit on the number of hearing aids per ear during the 36-month period. Both hearing aids and hearing tests are subject to your plan's deductible and copayments. Replacement batteries and supplies are not covered.

Home health care services: Covers treatment provided in your home on a part-time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that provides the quality and appropriate level of care to treat your condition. To ensure benefits, your doctor must provide a description of the treatment you will receive at home. Your coverage includes the following home health services: visits by a licensed health care professional, including a nurse, therapist, or home health aide; and physical, speech, and occupational therapy (services provided as part of home health are not subject to dollar-limits). These services are only covered when your condition confines you to home at all times except brief absences.

Home private duty nurse's services: Medically skilled services of a currently licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in your home when the nurse is not a relative or member of your family. Your doctor must certify to us that private duty nursing services are medically necessary for your condition, and not merely custodial in nature.

Hospice care services: For covered members diagnosed with a terminal illness with a life expectancy of six months or less. Covered services include the following: skilled nursing care, including IV therapy services; drugs and other outpatient prescription medications for palliative care and pain management; services of a medical social worker; services of a home health aide or homemaker; short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the covered person in order to provide the covered person's primary caregiver a temporary break from caregiver responsibilities. Respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided for more than five days every 90 days; physical, speech, or occupational therapy (services provided as part of hospice care are not subject to dollar limits); medical equipment (durable); routine medical supplies; routine lab services; counseling, including nutritional counseling with respect to the covered person's care and death; and bereavement counseling for immediate family members both before and after the covered person's death.

Hospital services: The hospital and doctors' services when you are treated on an outpatient basis or when you are an inpatient because of illness, injury, or pregnancy. (See Maternity below for an additional discussion of pregnancy benefits.) The Medical Plan covers medically necessary care in a semi-private room or intensive or special care unit. This includes your bed, meals, special diets, and general nursing services. In addition to your semi-private room, general nursing services and meals, the Medical Plan covers allowable charges for medically necessary services and supplies furnished by the hospital when prescribed by your doctor or provider. The hospital must meet the American Hospital Association's standards for registration as a hospital. Remember that your share of the cost of covered services

changes if you use a doctor, facility, or other health care provider that is outside of the network. While you are an inpatient in the hospital, the Plan covers the medically necessary services rendered by doctors and other covered providers. The Plan covers the private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, inpatient benefits would cover the hospital's charges for a semi-private room. If you choose to occupy a private room, you are responsible for paying the daily differences between the semi-private and private room rates in addition to your copayment and coinsurance (if any). If the hospital has only private rooms, the Plan would cover an amount determined to be the most common semi-private room charge for hospitals in the community.

Infusion services: Treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

LiveHealth Online Visits: When available, in areas where both a consultation and prescription are allowed. Your coverage will include online visit services with a physician or a therapist. Covered Services include a medical or psychological consultation using the internet via a webcam, chat or voice. See the Summary of Benefits table for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Non Covered Services include, but are not limited to communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification;
- Physician to Physician consultation.

Maternity (prenatal and newborn care): If you become pregnant, the Plan provides several coverage features. Maternity care, maternity-related checkups and delivery of the baby in the hospital are covered by the Medical Plan. Benefits include use of the delivery room and care for normal deliveries; home setting covered with nurse midwives; anesthesia services to provide partial or complete loss of sensation before delivery; routine nursery care for the newborn during the mother's normal hospital stay; prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary; initial examination of a newborn and circumcision of a covered male dependent; services for interruption of pregnancy; and fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

If the doctor submits one bill for delivery, prenatal, and postnatal care services, payment is made at the same level as inpatient professional provider services. If the doctor bills for these services separately, your payment responsibility is determined by the services received.

You are eligible to participate in the Anthem Future Moms program. This program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A Future Moms consultant is assigned to women identified as having greater risk of premature delivery. The consultant (a nurse or health educator) works with the mother and her doctor during the pregnancy to determine what may be needed to help achieve a full-term delivery. As soon as pregnancy is confirmed, sign up for the program by calling 1-800-828-5891. You receive: a kit containing educational material on how to get proper prenatal care and identify signs of premature labor; a risk appraisal to identify signs of premature labor; and after delivery, a birth kit and child care book.

Future Moms with Breastfeeding Support on LiveHealth Online offers moms online visits with a lactation consultant, counselor or registered dietitian through private and secure video using their smartphone, tablet or computer. Online visits using Future Moms with Breastfeeding Support on LiveHealth Online are available at no extra cost.

The Plan generally may not, under federal law (Newborns' and Mothers' Health Protection Act), restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours for a 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, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

Medical equipment (durable): The rental (or purchase if that would be less expensive) of durable medical equipment required for therapeutic use when prescribed by your doctor. Also covered are maintenance and necessary repairs of medical equipment (durable) except when damage is due to neglect. Coverage includes the following types of equipment: nebulizers; hospital type beds; wheelchairs; traction equipment; walkers; and crutches.

Medical devices and appliances: The cost of fitting, adjustment, and repair of the following items when prescribed by your doctor for activities of daily living: artificial limbs, including accessories; orthopedic braces; leg braces, including attached or built up shoes attached to the leg brace; molded, therapeutic shoes for diabetics with peripheral vascular disease; arm braces, back braces, and neck braces; catheters and related supplies; orthotics other than foot orthotics; head halters; and splints.

Medical formulas: Special medical formulas that are the primary source of nutrition for covered persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

Medical supplies and medications: If prescribed by a covered provider. Examples of medical supplies include: hypodermic needles and syringes; catheters; allergy serum; oxygen and equipment for its administration; and prescription medications infused through IV therapy in the physician's office or outpatient facilities.

Mental health and substance abuse services:

- Inpatient care for mental health and substance abuse services including individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, and convulsive therapy treatment. The availability of benefits for inpatient mental health services and substance abuse services is subject to the results of your Hospital Admission Review. To be covered, inpatient services for substance abuse treatment must not be merely custodial, residential, or domiciliary in nature and must be provided in a hospital or substance abuse treatment facility that is licensed to provide a continuous, structured, 24-hour-a-day plan of drug or alcohol treatment and rehabilitation including 24-hour-a-day nursing care. The Plan also covers "partial day" mental health and substance abuse services. Obtaining authorization in advance is recommended.
- Outpatient mental health services include treatment for outpatient mental health and substance abuse services. Obtaining authorization in advance is recommended. Visits to your doctor to make sure that medication you are taking for a mental health or substance abuse problem is working and the dosage is right for you are covered under the Medical Plan.

- Methadone for heroin addiction can only be obtained through a federally certified clinic. It cannot be obtained through a pharmacy (methadone when obtained through a pharmacy is generally prescribed for pain relief).

Prescription drugs: Prescription drugs are medicines that require a prescription order from your doctor. These are also known as legend drugs, or drugs which federal law stipulates can only be obtained with a prescription. The Plan covers eligible *prescription drugs* if received through a pharmacy, a doctor's office, or a hospital. Prescriptions filled at a licensed pharmacy are covered under the prescription drug portion of the plan through Express Scripts. Any prescription drugs that you receive at a doctor's office, clinic or hospital are covered under the medical portion of the plan through Anthem and considered for coverage in the same manner as other medical services or supplies.

Prescription drugs covered under the prescription drug benefit include, but are not limited to, the following:
Most injectable drugs supplied by a licensed pharmacy;
Topical therapies;
Anabolic drugs;
Androgen drugs;
Certain compounded drugs (with a covered prescription drug included), as determined by Express Scripts, the prescription drug Claims Administrator;
Diabetic supplies;
Influenza treatments;
Migraine medications;
Interferons;
Insulin;
Contraceptives;
Legend vitamins;
Multiple sclerosis agents;
Oncology therapies;
Transplant therapies;
Immunosuppressants; and
Immunizations
Certain smoking cessation drugs are covered at a $0 copay in compliance with the Affordable Care Act (ACA). The drugs covered are generic prescription drugs, generic over-the-counter drugs and Chantix for covered individuals age 18 and older.

Certain drugs and/or quantities of drugs may require prior review and approval before payment is authorized.

Preventive care services:

- **Well baby care:** When care is received in-network, Well Baby benefits include coverage for routine care, screenings, checkups, and immunizations for your child through age 6. These services are based on the recommendations of the American Academy of Pediatrics, and include the following: complete physical examinations, developmental assessment and guidance; immunizations such as diphtheria, tetanus, pertussis (DTP), polio, measles, mumps, rubella (MMR), hemophilus vaccine (HIB), hepatitis B, varicella virus (chicken pox) vaccine, pneumococcal conjugate vaccine, influenza, Rotavirus and other immunizations as may be prescribed by the Commissioner of Health; and certain laboratory and screening tests, including infant hearing and vision tests required for preschool physical exam. The American Academy of Pediatrics recommends the following schedule for well child care visits:

Birth	2 months	9 months	18 months	4 years
2-4 days	4 months	12 months	2 years	5 years
2-4 weeks	6 months	15 months	3 years	6 years

The Plan also provides coverage for routine tests, lab and x-ray services for each covered individual.

- **Routine preventive care:** For ages 7 and older, in-network benefits are provided for:
  - Office visit for annual checkup (once each calendar year);
  - Annual gynecological exam and Pap smear (once each calendar year) performed by any FDA-approved gynecologic cytology screening technologies;
  - Annual mammogram (once each calendar year) for women;
  - Annual colorectal cancer screening (once each calendar year) such as an annual fecal occult blood test; flexible sigmoidoscopy; colonoscopy or barium enema. These services are provided in accordance with the age, family history and frequency recommendations of the American College of Gastroenterology, in consultation with the American Cancer Society;
  - Annual prostate exam and PSA test (once each calendar year) for men;
  - -- Immunizations (routine vaccines) to prevent or reduce the risk of conditions such as tetanus, flu, or human papillomavirus (HPV). Some immunizations require prior approval. Covered immunizations may be purchased in or out-of-network under both Anthem and Express Scripts; and
  - Routine tests, lab and x-ray services billed with annual check-up and/or GYN exam.

  Note: Benefits are paid based on information billed by the provider. If a preventive care visit, other than an annual mammogram or colorectal cancer screening, results in your doctor identifying or treating a medical condition (for example, your child is sick on the day of a scheduled routine checkup), the claim is processed under your medical benefits (deductible/copayment) instead of the preventive care benefit. An annual mammogram and colorectal cancer screening will be paid under your preventive care benefit even if your doctor determines there is a medical condition.

  If you are uncertain whether a particular service will be covered under the preventive care benefit, confirm with Anthem Customer Service at 1-800-348-1966 prior to having the service performed.

Residential Treatment Centers: Non-skilled sub-acute inpatient settings such as residential treatment centers (RTCs), partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs) that qualify as substance abuse treatment facilities licensed to provide a continuous, structured, 24 hour-a-day program of drug or alcohol treatment and rehabilitation including 24 hour-a-day nursing care. In- and out-of-network services are covered only if facilities are licensed, accredited, and treatment is pre-certified.

Shots (Injections): Therapeutic injections (shots) that a provider gives to treat illness (e.g., allergy shots) or pregnancy-related conditions.

Skilled nursing facility: Skilled nursing home stays. Coverage for your stay must be approved in advance. Your doctor must submit a plan of treatment that describes the type of care you need. The following items and services are provided to you as an inpatient in a skilled nursing bed of a skilled nursing facility: room and board in semi-private accommodations; rehabilitative services; and drugs, biologicals and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies. Custodial or residential care in a skilled nursing facility or any other facility is not covered except as rendered as part of Hospice care.

Spinal manipulation and other manual medical interventions: Spinal manipulation services (manual medical interventions) and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations such as massage and myofascial release.

Surgery: charges for surgery when treatment is received at an inpatient, outpatient or ambulatory surgery facility or doctor's office:

- **Bariatric surgery:** Treatment of obesity through gastric bypass, or other methods recognized by the National Institutes of Health (NIH) and in accordance with NIH guidelines for recommending surgery. Coverage is restricted to surgical procedures and does not include weight control dietary supplements. Bariatric surgery must be approved by Anthem for the type of surgery requested and must be authorized prior to being performed. Charges for services that are not authorized for the surgery requested will not be considered covered services. For more information, refer to Anthem Blue Cross Blue Shield's Clinical Policy Bulletin: *Bariatric Surgery and Other Treatments for Clinically Severe Obesity*. Clinical Policy Bulletins can be found at https://www.anthem.com/dam/medpolicies/abcbs_va/active/guidelines/gl_pw_a051166.html.**Oral surgery:** Surgical removal of impacted wisdom teeth; maxillary or mandibular frenectomy when not related to a dental procedure; alveolectomy when related to tooth extraction; orthognathic surgery that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part; surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures; and the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; or
- **Organ and tissue transplants, transfusions:** The Plan covers organ and tissue transplants and transfusions. When a human organ or tissue transplant is provided from a living donor to you and both the recipient and the donor are covered by the Medical Plan, both may receive the benefits of the Plan. Autologous bone marrow transplants for breast cancer are only covered when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the Plan of experimental/investigative services.
- **Reconstructive breast surgery and mastectomy**: If you are receiving mastectomy benefits and elect breast reconstruction in connection with the mastectomy, the Medical Plan provides coverage for: reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the unaffected breast to produce a symmetrical appearance, prostheses and physical complications of mastectomy, including lymphedema. Covered services are provided in a manner determined in consultation between the attending physician and the patient. Reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to reestablish symmetry between two breasts is also covered. Benefits are provided as for any other covered surgical expense. Benefits related to breast reconstruction are in compliance with the requirements of The Women's Health and Cancer Rights Act of 1998.

Therapy: The following therapies are covered when the treatment is medically necessary for your condition and provided by a licensed therapist:

- **Cardiac rehabilitation therapy** treatment to restore and maintain the physiological, psychological, social and vocational capabilities of patients with heart disease;
- **Chemotherapy** treatment of disease by chemical or biological antineoplastic agents;
- **Occupational therapy** treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing;

- **Physical therapy** treatment by physical means to relieve pain, restore function and prevent disability following disease, injury or loss of limb. Coverage includes physical therapy to treat lymphedema;
- **Radiation therapy** including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt or high-energy particle sources;
- **Respiratory therapy** including the introduction of dry or moist gases into the lungs to treat illness or injury; and
- **Speech therapy** treatment for the correction of a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly or prior medical treatment.

Vision correction after surgery or accident: the cost of prescribed eyeglasses or contact lenses only when required as a result of surgery, or for the treatment of accidental injury. Services for exams and replacement of these eyeglasses or contact lenses are covered only if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if: prescribed to replace the human lens lost due to surgery or injury; "pinhole" glasses are prescribed for use after surgery for a detached retina; or lenses are prescribed instead of surgery in the following situations: contact lenses are used for the treatment of infantile glaucoma; corneal or scleral lenses are prescribed in connection with keratoconus; scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

WHAT THE PLAN DOES NOT COVER

Some of the items that are not covered under the Medical Plan are listed below. This is *not* an all-inclusive list. This list will be interpreted and applied in accordance with the Affordable Care Act. Accordingly, an item on this list may nevertheless be covered if, in your individual circumstances, the item qualifies as “preventive care” required to be covered under the Affordable Care Act. *If you have a question about whether a treatment or service is covered under the Plan, you should contact Anthem Customer Service* 1-800-348-1966 *prior to receiving the service.*

Acupuncture.

Admissions for Non-Inpatient Services - Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an inpatient basis.

Alternative Therapies - Hypnotherapy, acupuncture and acupuncture therapy. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris. This exclusion also applies to biofeedback, recreational or educational sleep therapy or other forms of self-care or non-medical self-help training and any related diagnostic testing.

Biofeedback therapy.

Chiropractic services in excess of 20 visits per person per year**.**

Over the counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads and ice bags.

Cosmetic surgery or **procedures**, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person’s

appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. The patient's mental state is not considered in deciding if the surgery is cosmetic.

The following **dental** services:

- Treatment of natural teeth due to diseases;
- Treatment of natural teeth due to accidental injury occurring on or after your effective date of coverage, unless treatment was sought with 60 days after the injury and you submitted a treatment plan to Anthem for prior approval;
- Dental care, treatment, supplies or dental x-rays;
- Damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered;
- Oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures;
- Appliances for temporomandibular joint pain dysfunction; or
- Periodontal care, prosthodontal care, or orthodontic care.

Educational or teacher services except as specifically described in this SPD.

Experimental/investigative procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute.

The following **family planning** services:

- Services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
- Drugs used to treat infertility; or
- Reversals of sterilization.

Foot Care: Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, foot orthotics, subluxations of the foot, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for medically necessary foot care required as part of the treatment of diabetes and for members with impaired circulation to the lower extremities.

The following **home care** services:

- Food, housing, homemaker services, sitters, home-delivered meals.
- Home Health Care services which are not medically necessary or of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care plan as described.
- Services of a person who ordinarily resides in the member's home or is a member of the family of either the member or member's Spouse.
- Any services for any period during which the member is not under the continuing care of a Physician.
- Convalescent or Custodial Care where the member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the member.
- Any services or supplies not specifically listed as Covered Services.
- Routine care and/or examination of a newborn child.
- Dietician services.

- Maintenance therapy.
- Dialysis treatment.
- Purchase or rental of dialysis equipment.

The following **hospital** services:

- Guest meals, telephones, televisions, and any other convenience items received as part of your inpatient stay;
- Care by interns, residents, house physicians, or other facility employees that are billed separately from the facility; or
- A private room unless it is medically necessary; or
- Non-emergency travel expenses and take-home supplies.

Medical equipment (durable), appliances and devices and medical supplies that have both a non-therapeutic and therapeutic use. These include:

- Exercise equipment;
- Air conditioners, dehumidifiers, humidifiers, and purifiers;
- Hypoallergenic bed linens;
- Whirlpool baths;
- Handrails, ramps, elevators, and stair glides;
- Telephones;
- Adjustments made to a vehicle;
- Foot orthotics;
- Changes made to a home or place of business; or
- Repair or replacement of equipment you lose or damage through neglect.

Coverage does not include benefits for medical equipment (durable) that is not appropriate for use in the home.

Services and supplies if they are deemed not **medically necessary** as determined by the Claims Administrator at its sole discretion.

The following **mental health services and substance abuse services**:

- Inpatient stays for environmental changes;
- Cognitive rehabilitation therapy;
- Educational therapy;
- Vocational and recreational activities;
- Coma stimulation therapy;
- Services for sexual deviation and dysfunction;
- Treatment of social maladjustment without signs of psychiatric disorder;
- Remedial or special education services;
- Inpatient mental health treatments that meet the following criteria:
  - More than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital;
  - Group psychotherapy when there are more than 8 patients with a single therapist;
  - Group psychotherapy when there are more than 12 patients with two therapists;
  - More than 12 convulsive therapy treatments during a single admission; or
  - Psychotherapy provided on the same day of convulsive therapy.

Nutrition counseling and related services, except when provided in relation to eating disorders or as part of diabetes education.

Care of **obesity** or services related to weight loss or dietary control including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies) are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery. (*Note: Except for services specifically described in this SPD under the section WHAT THE PLAN COVERS - Surgery - Bariatric Surgery*).

Paternity testing.

The **Prescription Drug** Program does not include coverage for the following:

- Drugs that are excluded from the formulary, and are not covered as a non-formulary drug, as determined by the prescription drug Claims Administrator or any third-party reviewer, such as MCMC.
- Over-the-counter (non-legend) drugs or supplies;
- Any prescription dispensed with a day's supply in excess of the Plan's maximum;
- Drugs used for cosmetic purposes;
- Drugs that are experimental, investigative or not approved by the FDA;
- Cost of medicine that exceeds the allowable charge for that prescription;
- Drugs for weight loss and drugs used to suppress appetite and control fat absorption;
- Drugs not prescribed for or approved by the FDA in the treatment of certain conditions;
- Certain smoking cessation aids, except those approved and required by the ACA;
- Therapeutic devices or appliances;
- Charges to inject or administer drugs;
- Drugs not dispensed by a licensed pharmacy;
- Drugs not prescribed by a licensed provider;
- Any non-controlled medication refill dispensed after one year from the date of the original prescription order;
- Medicine covered by workers' compensation, occupational disease law, state or government agencies;
- Drugs, supplies or medication covered under the medical portion of the Plan;
- Drugs that do not meet the criteria for coverage under the prescription drug programs (including, but not limited to prior authorization, quantity limits and step therapy) as determined by the prescription drug Claims Administrator or any third party reviewer, such as MCMC;
- Medicine furnished by any other drug or medical service;
- Erectile dysfunction drugs;
- Hair growth stimulants;
- Nutritional supplements (including over-the-counter and prescription items) for providing complete or supplemental nutritional support;
- Non-legend vitamins and minerals;
- Durable medical equipment;
- Legend homeopathic drugs;
- Drugs that are determined to be not medically necessary, as determined by the Claims Administrator;
- Fertility medications;
- Respiratory therapy supplies;
- Syringes other than insulin, or;
- Certain compound drugs as determined by Express Scripts, the prescription drug Claims Administrator.

Private duty nurses in the inpatient setting.

Rest cures, custodial **residential care** or domiciliary care and services. Whether care is considered residential is determined based on factors such as whether the member receives active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic services.

Benefits for care from a **residential treatment center** or other non-skilled sub-acute inpatient settings, except to the extent such setting qualifies as a substance abuse treatment facility licensed to provide a continuous, structured, 24 hour-a-day program of drug or alcohol treatment and rehabilitation including 24 hour-a-day nursing care.

Services or supplies if they are:

- Ordered by a doctor whose services are not covered services under your health plan;
- Care of any type given along with the services of an attending provider whose services are not covered;
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury;
- Not listed as covered services under your Plan;
- Not prescribed, performed, or directed by a provider licensed to do so;
- Received before the effective date or after your coverage ends;
- Telephone consultations, charges for not keeping appointments, or charges for completing claim forms;
- For travel, whether or not recommended by a physician (except as provided under the Preventive Care immunization benefit);
- Given by a member of your immediate family;
- Provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not you waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payer after benefits under this plan have been paid. The Plan pays for covered services when these program benefits have been exhausted;
- Provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost;
- Received from an employer mutual association, trust, or a labor union’s dental or medical department; or
- Any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military facilities except as required by law.

Services for which a charge is not usually made. This includes services for which you would not have been charged if you did not have health care coverage.

Services or benefits for:

- Amounts above the allowable charge for a service;
- Self-administered services or self-care;
- Self-help training; or
- Biofeedback, neurofeedback and related diagnostic tests.

The following **skilled nursing** facility stays:

- Treatment of psychiatric conditions and senile deterioration; or

- Facility services during a temporary leave of absence from the facility.

Spinal manipulations or other manual medical interventions for an illness or injury other than musculoskeletal conditions.

The following **therapies**:

- Physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services;
- Group speech therapy;
- Group or individual exercise classes or personal training sessions; or
- Recreation therapy. This includes, but is not limited to, sleep, dance, art, crafts, aquatic, gambling and nature therapy.

The following **vision services**:

- Services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, astigmatism, and/or farsightedness. This type of surgery includes radial keratoplasty and Lasik procedure;
- Vision services or supplies unless needed due to eye surgery and accidental injury;
- Services for vision training and orthoptics;
- Tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury;
- Lenses, frames, sunglasses or safety glasses of any type;
- Experimental/investigative vision procedures or materials, as well as services related to or complications from such procedures;
- Services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer; or
- Any other vision services not specifically listed as covered.

Services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not you reach a settlement with the employer or the employer's insurer or self-insurance association because of the injury or diseases.

HOSPITAL ADMISSION REVIEW

All hospital stays, skilled nursing home stays, or treatment in partial day programs should be approved before each admission. If you are admitted to the hospital as a result of an emergency, your hospital stay should be reviewed by Anthem within 48 hours of admission or on the next business day. The emergency room doctor, a relative, or a friend can call for Hospital Admission Review. While network providers and facilities generally handle Hospital Admission Review for you, it ultimately is your responsibility to be sure that Hospital Admission Review is completed. Inpatient stays that are not medically necessary are not covered by the Plan. You must initiate the Hospital Admission Review process for out-of-network services.

Before you are admitted to the hospital for medical care or surgery, you, your doctor, or someone you authorize, must call Anthem at 1-800-348-1966. You should have the following information available:

- Your Anthem Blue Cross and Blue Shield identification number (shown on your ID card);
- Your doctor's name and phone number;

- The date you plan to enter the hospital and length of stay; and
- The reason for hospitalization.

Anthem must respond to a Hospital Admission Review request within 24 hours of receipt or on the next business day, whichever is later, unless more information is needed in order to make a decision. You must receive a response from Anthem before non-emergency service is provided.

Hospital admissions for a covered radical or modified radical mastectomy for the treatment of breast cancer must be authorized for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be authorized for a period of no less than 24 hours.

Anthem Hospital Admission Review continues while you are in the hospital. Anthem physicians and nurses regularly review the medical necessity of continuing inpatient coverage while you are hospitalized. An Anthem nurse may contact you and your physician if more information is needed.

If you still need care after your discharge from the hospital, Anthem may coordinate alternative coverage to help you recover. Some of the benefits that can be arranged in place of hospitalization include: home health care, care in a skilled nursing home, and home intravenous (IV) therapy. Only your medical condition (not your financial or family situation, the distance you live away from the place of treatment, or any other non-medical factor) is considered in deciding which setting is necessary. As a patient's medical condition changes, the need for a particular setting may change.

If a catastrophic illness or injury occurs and you need long-term care, Anthem continues to work with you and your doctors to help plan for care in appropriate settings such as a skilled nursing home or your home. Anthem evaluates the need for special services and additional benefits to help ensure that the patient receives the most appropriate care and to help control the financial impact of that care on you.

COORDINATION OF BENEFITS

Special coordination of benefits (COB) rules apply when you or members of your family have additional health care coverage through other group health plans, including:

- Group insurance plans, including other Blue Cross and Blue Shield plans or HMO plans;
- Labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- Coverage under any tax-supported or government program to the extent permitted by law.

When a covered person is also enrolled in another group health plan, one coverage is primary and one is secondary. The decision of which coverage is primary or secondary is made using order of benefit determination rules. Highlights of these rules are described below:

- If the other coverage does not have COB rules substantially similar to this Plan’s, the other coverage is primary.
- If a covered person is enrolled as the employee under one coverage and as a dependent under another, generally the one that covers the person as the employee is primary.
- If a covered person is the employee under both coverages, generally the one that covers the person for the longer period of time is primary.
- If your dependent child is enrolled under two coverages (for example, when both parents cover the child), typically the coverage of the parent whose birthday falls earliest in the calendar year is primary.
- Special rules apply when a dependent child is enrolled under two coverages and the child’s parents are separated or divorced. Generally, the coverage of the parent or stepparent with custody is primary. However, if there is a court order that requires one parent to provide for

medical expenses for the child, that parent's coverage is primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the calendar year is primary.

When the Plan provides secondary coverage, in no event does the Plan's payment exceed the amount that would have been payable had the Plan been primary. The Plan coordinates benefits so that the combination of the primary plan's payment and the Plan's payment does not exceed the Plan's allowable charge. When the primary plan provides benefits in the form of services rather than payment, a reasonable cash value of the services is assigned and then considered to be the benefit payment.

When a covered person is also covered by Medicare, coordination of benefits will be determined in accordance with the relevant laws, regulations and rulings of the Medicare program.

This coordination of benefits provision does not apply to the prescription drug portion of the Plan, nor does it affect any personal coverage you may have purchased on your own.

If the Medical Plan overpays benefits because of COB, Anthem has the right to recover the excess from any person to, or for whom, such payments were made; any insurance company; or any other organization. You are required to cooperate with Anthem to secure this right.

SUBROGATION AND REIMBURSEMENT

These provisions apply when your Dominion Energy plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

Subrogation
The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the plan to exercise the plan's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fail to do whatever is necessary to enable the plan to exercise its subrogation rights, the plan shall be entitled to deduct the amount the plan paid from any future benefits under the plan.
- The plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the plan's subrogation claim and any claim held by you, the plan's subrogation claim shall be

first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- The plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.

Reimbursement

If you obtain a Recovery and the Dominion Energy plan has not been repaid for the benefits the plan paid on your behalf, the plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the plan from any Recovery to the extent of benefits the plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the plan shall have a right of full recovery, in first priority, against any Recovery. Further, the plan's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the plan the proceeds of the gross Recovery (*i.e.*, the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the plan immediately upon your receipt of the Recovery. You must reimburse the plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.
- If you fail to repay the plan, the plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the plan has paid or the amount of your Recovery whichever is less, from any future benefit under the plan if:
    1. The amount the plan paid on your behalf is not repaid or otherwise recovered by the plan; or
    2. You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the plan, the plan shall be entitled to deduct the amount of the plan's lien from any future benefit under the plan.
- The plan shall also be entitled to recover any of the unsatisfied portion of the amount the plan has paid or the amount of your Recovery, whichever is less, directly from the providers to whom the plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and the plan will not have any obligation to pay the provider or reimburse you.
- The plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must notify the plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the plan in the investigation, settlement and protection of the plan's rights. In the event that you or your legal representative fail to do whatever is necessary to enable the plan to exercise its subrogation or reimbursement rights, the plan shall be entitled to deduct the amount the plan paid from any future benefits under the plan.
- You must not do anything to prejudice the plan's rights.
- You must send the plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the plan if you retain an attorney or if a lawsuit is filed on your behalf.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

If you, the employee, fail to comply with the subrogation policy and procedures, medical coverage for you and all your dependents may be canceled, if consistent with applicable law, effective the end of the month you are notified by Dominion Energy. If your dependent(s) fail to comply with the subrogation policy and procedures, the plan may cancel medical coverage for those dependent(s), if consistent with applicable law, at the end of the month you are notified by Dominion Energy.

Medical coverage can be reinstated effective the first of the month following the date you and/or your dependent(s) have fully complied with the subrogation policy and procedures, provided that you and/or your dependent(s) have fully complied by December 31 of the year in which the coverage was canceled. However, claims incurred during a period of cancellation are not covered by the plan.

BALANCE BILLING

"Balance billing," also known as "surprise billing" can occur when you use an out-of-network provider, and the provider bills you for the difference between the provider's total charge and the amount the Plan covers as the allowable charge. When you receive care and/or treatment from an out-of-network provider under circumstances in which you have no choice in selecting that provider, in certain cases your claim can be processed as if it was an in-network claim. A common example is when you use a network hospital and a network surgeon, but the anesthesiologist on duty at the time of your treatment does not participate in the network. If you receive a balance bill under these or similar circumstances, you can contact Anthem and request that they review your claim. This applies to anesthesiologists, radiologists, pathologists, and assistant surgeons (RAPS providers). It does not include neuromonitoring services.

For consideration of payment for out-of-network services at an in-network benefit level for services other than RAPS providers, you must obtain pre-authorization from Anthem by calling Anthem Customer Services at 1-800-348-1966 before you receive the service.

The law also provides some specific protections against balance billing. In particular, you are protected from balance billing for:

- *Emergency services*. If you have an emergency medical situation and receive emergency services from an out-of-network doctor or facility, the most the doctor or facility may bill you is your plan's in -network cost-sharing amount (such as copays and coinsurance). You cannot be balance billed for these emergency services. This includes services you may receive after you're in stable condition, unless you give written consent to give up your protections against balance billing for these post-stabilization services.

- *Certain services at a hospital or ambulatory surgical center in your plan's network*. When you receive services from a hospital or ambulatory surgical center (places that perform outpatient surgeries) in your plan's network, certain doctors or specialists there may be out-of-network. In these cases, the most they may 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 specialists cannot balance bill you and cannot ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network doctors or other healthcare professionals cannot balance bill you, unless you give written consent to give up your protections.

You're never required to give up your protections against balance billing. You also aren't required to receive care out of your plan's network. 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 copay, coinsurance, and deductibles that you would pay if the doctor or facility was in your plan's network). Your health plan will pay out-of-network doctors and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (also called prior authorization).
  - Cover emergency services by out-of-network doctors or specialists.
  - Base what you owe the doctor or facility (cost-sharing) on what it would pay a doctor or facility in your plan's network and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you think you've been wrongly billed, you can contact the Employee Benefits Security Administration (EBSA), the No Surprise Help Desk (NSHD) at 1-800-985-3059 or cms.gov/nosurprises to ask whether the charges are allowed by law. You may also find additional information about surprise billing on Anthem's website at https://www.anthem.com/no-surprise-billing/. Anthem's website can also provide you with information on network negotiated rates and out-of-network rates.

FILING CLAIMS

Most providers file your claim directly with Anthem Blue Cross and Blue Shield. It is important that claims are filed as soon as possible. It is ultimately your responsibility to ensure that claims are filed in a timely manner. Only claims submitted within 12 months following the end of the year in which a service was performed are considered for payment.

When you are treated by a doctor or admitted to the hospital, always present your Anthem Blue Cross and Blue Shield identification card:

- If the doctor or hospital participates with the Anthem Blue Cross and Blue Shield PPO Network, they automatically submit a claim for services you receive. The Plan makes payment for covered services directly to the provider. If you have already paid the provider and you submit the claim directly to Anthem Blue Cross and Blue Shield, the Plan pays you;
- If the doctor or hospital is *not* a PPO participating provider, you may be required to submit the claim yourself; or
- If you receive services for supplies such as durable medical equipment, ambulance services, or private duty nursing services, you may be required to submit the claim yourself.

When you submit a claim, you must attach an itemized bill. Itemized bills must contain: the name and address of the person or organization providing services or supplies, name of the patient receiving services or supplies, date services or supplies were provided, the charge for each type of service or supply, a description of the services or supplies received, and a description of the patient's condition (diagnosis). In addition private duty nursing bills must include the professional status of the nurse (for example, RN for registered nurse), the attending physician's written certification that the services were medically necessary and the hours the nurse worked. In some cases, documentation of medical necessity

is required. Payment is made to you in accordance with the terms of the Plan. A separate claim form must be completed for each patient. Send the completed claim form and itemized bills to Anthem Blue Cross and Blue Shield, P.O. Box 105187, Atlanta, FA 30348-5187.

You can obtain a Medical Claim Form on Dominion Energy's Benefits website, http://dombenefits.com, or by calling Anthem Customer Service at 1-800-348-1966, or the Dominion Energy HelpLine at 1-877-947-4636.

YOUR RIGHT TO APPEAL - Medical claims

For purposes of these appeal provisions, "claim for benefits" means a request for benefits under the applicable plan. The term includes pre-service, post-service, urgent care and concurrent care claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the claimant's life or health or ability to regain maximum function or would - in the opinion of a physician with knowledge of the claimant's medical condition - subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
  On receipt of a pre-service claim, Anthem will make a determination of whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim shall be treated as an urgent care claim.
- A concurrent care claim involves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of "concurrent care claims": (1) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and (2) where an extension is requested beyond the initially approved period of time or number of treatments.
- A post-service claim is any claim for a benefit under this plan that is not a pre-service claim, an urgent care claim, or a concurrent care claim. A claim submitted after the provider provides the service is a post-service claim.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

References to "you" and "your" in these appeal provisions refer to the claimant or to their authorized representative.

Notice of Adverse Benefit Determination
If your claim is denied, Anthem's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which Anthem's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along

with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:
- Anthem's notice will also include a description of the applicable urgent/concurrent review process; and
- Anthem may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Timing of Notification of Adverse Benefit Determination
- For non-urgent pre-service claims, you will be notified of the determination as soon as possible, but no later than 15 days from receipt of your claim. For circumstances beyond Anthem's control, the time period for making the initial claims determination may be extended by 15 days. If additional information is needed to determine your claim, you must provide it within 45 days of the date that you receive notice from Anthem.
- For non-urgent concurrent care claims, the following rules apply:
    - Where the concurrent care claim involves a decision to end or reduce treatment prematurely, you will be notified of the decision in time to finalize any appeal and obtain a determination on review before treatment ends.
    - Where the concurrent care claim involves a denial of your request to extend treatment, you will be notified of the determination as soon as possible but no later than 15 days from receipt of your claim. For circumstances beyond Anthem's control, Anthem may have one extension of 15 days for making the initial claims determination. If additional information is needed to determine your claim, you must provide it within 45 days of the date that you receive notice from Anthem.
- If your concurrent care claim involves urgent care, you will be notified of the determination within 24 hours of receipt of your claim, if your claim is submitted at least 24 hours before the scheduled end of the concurrent care treatment. If your claim is not received in this time period, then the claim will be treated as a pre-service urgent care claim, as described below.
- Determinations regarding pre-service urgent care claims will generally be made within 72 hours of receipt of your claim. If additional information is needed to determine your claim, you will have not less than 48 hours from the time you receive notice from Anthem to provide the specified information. Anthem must inform you that further information is needed to determine your claim within 24 hours of when it receives your claim. Anthem must then notify you of its decision within 48 hours after the earlier of the date the information is provided or the deadline for providing the missing information. Failure to provide the additional information may result in denial of your claim.
- For post-service claims, you will be notified of a denial as soon as possible, but no later than 30 days from the receipt of your claim. For circumstances beyond Anthem's control, Anthem may have one extension of 15 days for making the initial claims determination. If additional information is needed to determine your claim, you must provide it within 45 days of the date that you receive notice from Anthem.

Appeals
You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. Anthem's review of your claim will take into account

all information you submit, regardless of whether it was submitted or considered in the initial benefit determination. The time frame allowed for Anthem to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact Anthem at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the claimant or the claimant's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 105568
Atlanta, Georgia 30348

You must include your Member Identification Number when submitting an appeal.

Upon request, Anthem will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

Anthem will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, Anthem will provide you, free of charge, with the rationale.

How Your Appeal will be Decided
When Anthem considers your appeal, Anthem will not rely upon the initial benefit determination or, for voluntary second-level appeals, on the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal
If you appeal a pre-service or concurrent care claim involving urgent care, Anthem will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal a non-urgent pre-service claim or concurrent claim involving a denial of your request to extend treatment, Anthem will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, Anthem will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial
If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from Anthem will include all of the information set forth in the above section entitled “Notice of Adverse Benefit Determination.”

Voluntary Second Level Appeals
If you are dissatisfied with the plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review
If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to Anthem within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless Anthem determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review. Written requests for External Review should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 105568
Atlanta, Georgia 30348

You must include your Member Identification Number when submitting an appeal.

Within five business days after receipt of an external review request, the plan must complete a preliminary review. Within one business day after completing preliminary review, the plan must provide you with written notice of its preliminary review determination. If the request is complete, but not eligible for external review, the notice must include the reasons for its ineligibility. If the request is not complete, the notice must describe the information or materials needed to complete the request and advise you of your right to cure the defect by the end of the four month period or, if later, the 48-hour period following receipt of the notice.

If the request is complete and eligible for external review, the plan must assign an accredited independent review organization (IRO) to conduct the external review. The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through Anthem's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact Anthem at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

Immediately upon receiving a request for Expedited External Review, the plan must perform a preliminary review. The plan must then immediately send a notice that meets the requirements set forth above for standard External Review.

Upon determination that a request is complete and eligible for Expedited External Review, the plan will assign an IRO in accordance with the requirements set forth above for standard External Review. The IRO must provide notice of the final Expedited External Review decision as soon as possible, but in no event more than 72 hours after the IRO receives the request for Expedited External Review. If notice is not provided in writing, the IRO must provide written confirmation of its decision within 48 hours after providing the notice.

Requesting External Review is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable law, including ERISA.

YOUR RIGHT TO APPEAL – Prescription drug claims

You have the right to request that a medication be covered or be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan, such as medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

How to Request an Initial Coverage Review
To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at www.express- scripts.com/PA.

To request an initial administrative coverage review, you or your representative must submit the request in writing. You may obtain a Benefit Coverage Request Form, by calling the Customer Service phone number on the back of your prescription card.

Complete the form and mail it to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
Saint Louis, MO 63166-6587

Or fax it to 1-877-328-9660

If your situation meets the definition of urgent under the law, you may request an urgent review, which will be conducted as soon as possible, but no later than 72 hours from receipt of the request. In general, an urgent situation is one where, in the opinion of your provider, your health may be in serious jeopardy, or you may experience severe pain that cannot be adequately managed without the medication while you wait for a decision on the review. If you or your provider believe your situation is urgent, your provider must request the expedited review by phone at 1 800-753-2851.

How a Coverage Review is Processed
In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, you must submit information to Express Scripts to support your request. The initial determination and notification to you and the prescriber will be made within the specified timeframes as follows:

<table>
<tr><th>Type of claim</th><th>Decision Timeframe

Decisions are completed as soon as possible from receipt of request but no later than:</th><th colspan="2">Notification of Decision</th></tr>
<tr><td></td><td></td><td>Approval</td><td>Denial</td></tr>
<tr><td>Standard Pre-Service*</td><td>15 calendar days (Retail)

5 calendar days (home delivery)</td><td rowspan="2">Patient: automated call (letter if call not successful)

Prescriber: Electronic or Fax (letter if fax not successful)</td><td rowspan="2">Patient: letter

Prescriber: Electronic or Fax (letter if fax not successful)</td></tr>
<tr><td>Standard Post-Service*</td><td>30 calendar days</td></tr>
</table>

Urgent	72 hours**	Patient: automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Electronic or Fax (letter if fax not successful)

*If the information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to you and your prescriber informing you that the information must be received within 45 days or the claim will be denied.

**Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.

How to Request a Level 1 Appeal or Urgent Appeal After an Initial Coverage Review Has Been Denied

When an initial coverage review has been denied (adverse benefit determination), you or your representative may request an appeal within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, mail or fax the following information to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why you disagree with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests:
Express Scripts
Attn: Clinical Appeals Department
P.O .Box 66588
Saint Louis, MO 63166-6588

Or fax it to 1-877-852-4070

Administrative appeal requests:
Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
Saint Louis, MO 63166-6587

Or fax it to 1-877-328-9660

If your situation meets the definition of urgent (as described above), you may request an urgent appeal, which will be conducted as soon as possible, but no later than 72 hours from receipt of the request. If you or your provider believe your situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: phone 1-800-753-2851, fax 1-877- 852-4070

Administrative appeal requests: phone 1-800-946-3979, fax 1-877- 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a Level 1 Appeal or Urgent Appeal is Processed
Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a pharmacist, physician, trained prior authorization staff member, or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	**Decision Timeframe** Decisions are completed as soon as possible from receipt of request but no later than:	**Notification of Decision**	
		Approval	Denial
Standard Pre-Service	15 calendar days	Patient: automated call (letter if call not successful) Prescriber: Electronic or Fax (letter if fax not successful)	Patient: letter Prescriber: Electronic or Fax (letter if fax not successful)
Standard Post-Service	30 calendar days		
Urgent	72 hours	Patient: automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Electronic or Fax (letter if fax not successful)

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

How to Request a Level 2 Appeal After a Level 1 Appeal Has Been Denied
When a level 1 appeal has been denied (adverse benefit determination), you or your representative may submit a request for a level 2 appeal within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, submit the following information by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why you disagree with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber

statements/letters, bills or any other documents

Clinical appeal requests:
Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
Saint Louis, MO 63166-6588

Or fax it to 1-877-852-4070

Administrative appeal requests:
Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
Saint Louis, MO 63166-6587

Or fax it to 1-877-328-9660

If your situation meets the definition of urgent (as described above), you may request an urgent appeal, which will be conducted as soon as possible, but no later than 72 hours from receipt of the request. If you or your provider believe your situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: phone 1-800-753-2851, fax 1-877- 852-4070

Administrative appeal requests: phone 1-800-946-3979, fax 1-877- 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a Level 2 Appeal is Processed
Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a pharmacist, physician, or independent third-party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	**Decision Timeframe** Decisions are completed as soon as possible from receipt of request but no later than:	**Notification of Decision**	
		Approval	Denial
Standard Pre-Service	15 calendar days	Patient: automated call (letter if call not successful) Prescriber: Electronic or Fax (letter if fax not successful)	Patient: letter Prescriber: Electronic or Fax (letter if fax not successful)
Standard Post-Service	30 calendar days		

Urgent	72 hours	Patient: automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Electronic or Fax (letter if fax not successful)

Final Appeal with the Plan Administrator
If all levels of appeal have been exhausted with Anthem or Express Scripts, as applicable, the Medical Plan offers a voluntary level of appeal to the Dominion Energy Benefits Director. The purpose of the voluntary appeal procedure is to ensure that the Claims Administrator has received all necessary information and taken all appropriate steps to review your case. The Benefits Director does not review appeals if a medical judgment is involved. Anthem and Express Scripts, as the Claims Administrators of the Medical Plan, review and make all medical determinations after consultation with a qualified medical professional.

You must exhaust your appeal rights with Anthem or Express Scripts, as applicable, before filing a voluntary level of appeal with the Benefits Director. A voluntary level of appeal request must be submitted in writing within 180 days following the final determination of a claim by the Claims Administrator at the following address:

Dominion Energy Services, Inc.
Benefits Director
600 East Canal St. – 10th Floor
Richmond, VA 23219

The Benefits Director will review the appeal and take into account all the information you submit, regardless of whether the information was considered at the time the coverage decisions were made. The Benefits Director 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 a Claims Administrator. 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 Medical Plan. No fees or costs will be imposed on you as part of the voluntary level of appeal process.

ADDITIONAL APPEAL INFORMATION

Requirement to File an Appeal Before Filing a Lawsuit
You must exhaust the plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the plan. If your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

Dominion Energy reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

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 Director 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 Director 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.*

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 Director at the address below:

> Dominion Energy Services, Inc.
> Benefits Director
> 600 East Canal St. – 10th floor
> Richmond, VA 23219

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

The ABC 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.

SPECIAL COVERAGE RULES

There are a number of special coverage rules if you are enrolled in the Medical 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.

If You Work Past Age 65
If you or your spouse/domestic partner reach age 65 while you are still working for Dominion Energy, your coverage under the Medical Plan is primary (i.e., pays claims first) and Medicare is the secondary carrier.

If You Become Disabled
This section provides information about continuation of your medical coverage should you be awarded benefits under Dominion Energy's Long-Term Disability (LTD) Plan.

If you are covered under the Medical Plan at the time of your disability, you are eligible to enroll in the Disability and Survivors Medical Plan, which provides Option C medical coverage for as long as you remain disabled under Dominion Energy's LTD Plan. The cost of the coverage will be paid by Dominion Energy. Your coverage under the Disability and Survivors Medical Plan is effective when your coverage ends as an active employee with Dominion Energy.

LTD participants may continue to cover a spouse or other dependent who was covered during active employment, provided that they continue to meet the criteria for dependent eligibility under the active employee medical plan. Once an LTD participant drops a dependent, that dependent cannot later be re-enrolled.

If you are an employee under age 65 and totally disabled, you may qualify for Medicare in certain circumstances. If you qualify for Medicare, and you are covered under the Disability and Survivors Medical Plan, Medicare is generally your primary coverage and the Dominion Energy Plan is secondary. This means Medicare pays benefits first, then your remaining expenses are considered for reimbursement under the Dominion Energy Plan. Your claim is always paid as if you are receiving any Medicare benefits for which you are eligible, even if you are not actually enrolled.

However, if you are covered under Medicare solely because of end stage renal (kidney) disease, then the Dominion Energy Plan continues to be your primary coverage for the first 30 months. After this time period, Medicare becomes your primary source of coverage.

Upon your retirement, you may participate in the Retiree Health and Welfare Plan, if you were hired by Dominion Energy before January 1, 2019. See the "Retiree Medical Benefits" section of this SPD and the SPD for the LTD Plan for eligibility and coverage details.

When Active Employee Coverage Ends
Coverage for you under the Medical Plan continues through the last day of the month in which:

- Your employment with Dominion Energy terminates;
- You cease 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 reaching age 26 on the last day of the month during which they attain age 26.

If you die, coverage continues for your spouse and dependent children at no cost to them until the end of the month following the month in which your death occurred. Please refer to the "Survivor Medical Benefit" section for information concerning continued medical coverage.

If you or a covered family member are an inpatient in the hospital on the date coverage would otherwise end, benefits for inpatient hospital care and treatment will continue for that patient until the earliest of these events:

- The patient's hospital stay ends;
- You use up your maximum benefits;
- The patient becomes entitled to Medicare; or
- The patient becomes covered by another group health plan that doesn't have a waiting period.

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.

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

Converting Your Coverage
When coverage terminates, some Blue Cross Blue Shield organizations offer a conversion to an individual policy. Application must be made within 31 days after the end of the month in which coverage stopped. You will need to contact your local Blue Cross Blue Shield to determine if conversion is an option in a specific area.

RETIREE MEDICAL BENEFITS

Dominion Energy provides retiree medical benefits to eligible former employees and their eligible dependents under the Dominion Energy Ohio Union Retiree Health and Welfare Plan (the "Retiree Medical Plan"). You are eligible to participate in retiree medical coverage if you (a) were hired before January 1, 2019*, (b) are at least age 58** when you retire from active employment with Dominion Energy, and (c) have at least 10 years of pension service when you retire from active employment with Dominion Energy.

You have the option of commencing your Retiree Medical benefit immediately as of the first day of the month following your employment termination date or, effective for retirements on/after July 1, 2022, deferring coverage until a later date. This is a one-time opportunity to defer coverage for yourself and any

eligible dependents at the time of your retirement. Dominion Energy reserves the right to make changes to, or to terminate, these benefits after your retirement.

If you meet the eligibility requirements above, you are eligible to elect retiree medical coverage even if you were not covered under a Dominion Energy medical plan as an active employee. Note that domestic partners are not considered eligible dependents under the Retiree Medical Plan.

*Individuals hired or rehired on or after January 1, 2019 are not eligible for retiree medical benefits, provided, however, that retirees covered under the Retiree Medical Plan who return to active employment at Dominion Energy will be eligible for retiree medical benefits when they subsequently terminate employment.

** Retirements prior to January 1, 2022 had a minimum age requirement of 55.

When you elect retiree medical coverage, and only at that time, you may elect to cover or defer coverage for your spouse and/or eligible dependent children. If you do not elect retiree medical coverage for yourself, no Retiree Medical Coverage is available for your spouse and/or eligible dependent children. If you choose to defer Retiree Medical Coverage for yourself, Retiree Medical Coverage is deferred for your spouse and/or eligible dependent children. No spouse or dependent child can be added to your retiree medical coverage eligibility after your retirement date. Once you elect coverage for yourself, you may then elect coverage for your eligible spouse and/or dependent children, or you may continue to defer coverage for your spouse and/or children to a later date. Once enrolled, an individual who cancels coverage cannot later re-enroll in that coverage. If you cancel coverage for yourself, coverage also will be cancelled for any covered spouse and dependents at that time.

***Dependent Children*.** For purposes of retiree medical coverage, "dependent children" are defined as your **unmarried** children (including natural children, legally adopted children, children placed with you for adoption, stepchildren who live with you, and other children for whom you are the legal guardian and who live with you) who are:

- Under age 19;
- Age 19 up to age 25 and a full-time student (full-time student status is determined by the school your child attends); or
- Disabled, regardless of age, provided (1) they became disabled before age 19 (or before age 25 while a full-time student), (2) they were enrolled in the plan at the time they became disabled (or, in the case of a new retiree, they were covered under the Dominion Energy active medical plan prior to the employee's retirement), and (3) they remain continuously enrolled in the plan following the disability. "Disabled" means permanently and totally disabled by Social Security Administration standards, which generally means that the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for at least 12 months.

Note: A full-time student who is temporarily away from your home while at school continues to qualify as living with you. Also, dependents who are serving in the military of any country cannot be covered.

In addition to the above criteria, to be eligible for dependent Retiree Medical Coverage, your child must ***also*** meet one of the following two standards for dependency:

- **Standard #1** is met if you will provide more than half of the child's support for the year.
- **Standard #2** is met if the child meets an age, residency, relationship and support test for the year, as follows:
  - **Age**: The child must be either: (i) younger than age 19 at the end of the calendar year, **or** (ii) younger than age 24 at the end of the calendar year and a full-time student for at least 5 months during the year, **or** (iii) disabled. The child must also be younger than you, unless they qualify as disabled.
  - **Residency**: The child must live with you for more than half the year.
  - **Relationship**: The child must be your natural child, stepchild or legally adopted child, or one of the following for whom you are the legal guardian: a grandchild, sibling, stepsibling, niece or nephew.
  - **Support**: The child cannot provide more than half of their own support for the year. You do not have to count educational scholarships for full-time students as support.

Special rules apply if your child does not meet either of the two standards described above and you are divorced or legally separated or are living apart from your child's other parent for at least the last six months of the year. In such cases, your child is eligible as long as (i) the child receives more than one-half of their support from you and the other parent combined, (ii) the child lives with you and the other parent combined for more than one-half of the year, and (iii) the child meets either one of the standards above with respect to the child's other parent.

These rules can be very complicated. It is your responsibility to ensure that you enroll only those individuals who qualify as your dependent children.

If you die, your covered spouse and eligible children may continue coverage, provided they make the required contributions. If your spouse remarries, both your spouse and children become ineligible for coverage.

No person may be eligible for benefits as a retiree and as a dependent, or as a dependent of more than one retiree and/or employee.

Retiree Medical Coverage also applies if (1) you die while in either full-time or part-time active employment with Dominion Energy or while you are receiving benefits under the Dominion Energy LTD Plan, and (2) at the time of your death, you were otherwise eligible to retire and receive Retiree Medical Coverage; Eligible dependents must continue to make the required contributions for coverage to remain intact. If your spouse remarries, both your spouse and children become ineligible for coverage.

Coverage Before Medicare Eligibility
You are eligible to elect medical coverage that is similar to the active employee Option C. Differences under retiree medical coverage include (list is not comprehensive): the lifetime maximum is $4,000,000, domestic partners are not eligible dependents, copayments and annual benefit maximums apply to certain preventive care benefits, coverage for certain preventive care benefits required by the Affordable Care Act are not covered, dependent children over the age of 18 are covered only if they are full-time students under age 25, hearing aids are not covered, applied behavioral health, early intervention services are not covered, Health Pro and Teladoc services are not covered. However, if you were a Dominion Energy employee on December 31, 2006 and were age 61 or older on January 1, 2016, you are eligible for the retiree medical plan that was in effect prior to January 1, 2010 under the previous

collective bargaining agreement (Prior Option E). Dominion Energy reserves the right to make changes to these benefits after your retirement.

Coverage After Medicare Eligibility (at age 65 for employees who retire on or after January 1, 2016)
Effective January 1, 2016, Dominion Energy provides a health reimbursement account for eligible retiree medical participants who are over age 65. This account is funded solely by Dominion Energy and can be used to purchase health coverage on the open market, to supplement your Medicare coverage. The amount of Dominion Energy funding you will receive is based on your years of pension service at your retirement. To take advantage of this benefit, you must be enrolled in Medicare Parts A and B. For more details, please refer to the separate summary plan description for the Health Reimbursement Arrangement under the Retiree Health and Welfare Plan.

Coverage After Medicare Eligibility (for disabled individuals under age 65)
For participants who are not yet age 65, but who are eligible for Medicare due to a disability, retiree medical coverage is provided by a a) Medicare HMO if you reside in an area where there are Medicare HMOs, or b) the pre-Medicare retiree medical coverage. Medicare is your primary coverage and the plan coordinates benefits with Medicare. Claims are processed as if you were covered by Medicare Parts A and B, regardless of whether you enroll in Medicare. Therefore, if you do not enroll in Medicare when you first become eligible to do so, you are responsible for any payments that would have been made by Medicare had you timely enrolled. You will not receive duplicate payment for the same services from Medicare and the plan. Coverage under these plans ends when the participant turns age 65. Coverage is then provided under the health reimbursement account for participants who are over age 65.

Paying for Your Retiree Medical Plan Coverage

Retiree Medical Coverage
(pre-Medicare)
The amount you pay for retiree medical coverage is based on your age as of January 1, 2019 and the sum of your years of pension service and age when you retire.

(Pre-65 and disabled)
Participant who are pre-65 and eligible for Medicare due to disability pay the Medicare HMO premium if they reside in an HMO service area, until age 65.

Health Reimbursement Account Coverage (age 65 and older)
Please refer to the separate summary plan description for the Health Reimbursement Arrangement under the Retiree Health and Welfare Plan for detailed information on this coverage.

Retirees and surviving spouses must pay any required monthly contribution in order to have coverage under the plan. If contributions are not paid by the due date and coverage is terminated for non-payment, coverage will be terminated for the retiree or surviving spouse and any eligible dependents. Once coverage is terminated, it cannot be reinstated in the future.

When you retire, you will receive a retiree benefits enrollment kit that gives you details about the plan you are eligible for, and the costs associated with it.

SURVIVOR MEDICAL BENEFIT

In the event of your death while you are a regular full-time union employee, Dominion Energy provides a Survivor Medical benefit under the Disability and Survivors Medical Plan. Your surviving spouse and eligible dependent children may receive survivor medical benefits if they were, at the time of your death, covered dependents under your Medical Plan.

Note: If, at the time of your death, you were eligible to retire and receive Retiree Medical Coverage, your surviving spouse and eligible dependent children are provided Retiree Medical Coverage rather than the survivor medical benefit if they satisfy the requirements for enrollment in Retiree Medical Coverage. See the preceding section for details about Retiree Medical Coverage. If the Retiree Medical Coverage enrollment requirements are not satisfied, your surviving spouse and eligible dependent children will be eligible to enroll in the survivor medical benefit. (See "Enrollment," below.)

Eligibility
Eligibility for Survivor Medical benefits continues for your covered dependents until any one of the following events occurs for you:

- Loss of regular, full-time employment status;
- Furlough (educational, maternity, military) of more than three months;
- Leave of absence for more than three months;
- Inactive status of more than three months for reasons other than illness; or
- Receipt of Long-Term Disability benefits.

Additional dependents may not be added to this coverage unless the birth of a child occurs within 270 days of your death.

Enrollment
The medical coverage that was in force for your spouse/dependent(s) at the time of your death automatically continues for one month following the month in which you die. This additional month of coverage is provided by Dominion Energy at no cost to your spouse/dependent(s).

Your eligible spouse/dependent(s) will receive information from Benefits regarding enrollment in Survivor Medical. Enrollment is not automatic. The Survivor Medical benefit election must be made within 60 days following the end of the month of Dominion Energy-paid coverage.

Your eligible spouse/dependent(s) will be provided with the appropriate forms and instructions. Following these instructions will ensure that there is no lapse in medical coverage. Coverage under Survivor Medical may be elected on an individual basis. If Survivor Medical is elected, your spouse/dependent(s) will be covered under the same Medical Plan Option that was in effect at the time of your death.

**Note: If your spouse/dependent children are not required to pay any portion of the premium, they will be covered under the same Medical Plan Option that was in effect at the time of your death.*

Cost of Coverage
The cost of Survivor Medical coverage is determined as follows:

Employee's years of continuous full-time service at death	Cost to spouse/dependents
Fewer than 10 years	100% of total premium
10 but fewer than 20 years	75% of total premium
20 but fewer than 30 years	50% of total premium
30 or more years	0% of total premium

The first payment must be made within 45 days of the date your spouse/dependent(s) elect(s) to continue coverage. There can be no extension of this initial due date and no grace period is allowed. This payment could be for as much as four months of coverage. Once the initial payment is received, coverage is made retroactive to the date original coverage ended. Subsequent payments must be made monthly to the vendor, with each payment due in advance of the first day of each month. A 30-day grace period is

allowed. Failure to pay the required premium within the specified time period results in automatic termination of coverage. Payments postmarked on or before the last day of the grace period are accepted.

Premiums are subject to change from time to time. Your eligible surviving spouse/dependent children will be notified of changes.

Open Enrollment
Your eligible surviving spouse/dependent children will be provided with an opportunity each year to change Medical Plan options.

When Coverage Ends
Individuals electing Survivor Medical benefits may continue coverage until the occurrence of a disqualifying event. These events include:

- Eligibility for benefits under another group medical plan*;
- Eligibility for Medicare*;
- A covered child ceases to meet the Medical Plan's definition of a "dependent";
- A payment is not made on time; or
- If your spouse remarries, both your spouse and children would become ineligible for coverage.

*Note: Individuals who are eligible for, or covered by, another group medical plan or Medicare at the time of your death are not eligible for Survivor Medical.

In addition, a covered individual may elect to drop coverage at any time. *Once coverage is dropped, it cannot be reinstated.*

Covered individuals must notify the Dominion Energy Benefit Center within 60 days of the occurrence of any of the above events. They are required to reimburse Dominion Energy for any of its premiums and claim payments from the date coverage should have ended.

Survivor Medical Benefits or COBRA
Your eligible spouse/dependent may elect to continue current medical coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) rather than enrolling in Survivor Medical. However, by doing so, they may not elect to enroll in Survivor Medical at a later date. Likewise, if Survivor Medical is elected, your spouse/dependent(s) may not later switch to coverage under COBRA. Please refer to the “Additional Information” document.

Conversion Privileges
If Survivor Medical benefits end, your spouse/dependent(s) may request to convert the coverage to an individual policy. Some Blue Cross Blue Shield organizations offer a conversion to an individual policy. Application must be made within 31 days after the end of the month in which coverage stopped. Your spouse/dependent(s) must contact your local Blue Cross Blue Shield to determine if conversion is an option in a specific area.

Other Benefit Plans
Survivor Medical offers extended *medical* plan coverage only. Dental and/or vision coverage may only be continued under COBRA for up to 36 months. Please refer to the “Additional Information” document. Questions should be directed to the Dominion Energy Benefit Center at 1-877-434-6996.

CHANGING OR TERMINATING THE PLAN

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