MEDICAL PLAN

SUMMARY PLAN DESCRIPTION

FOR

EASTERN GAS TRANSMISSION AND STORAGE, INC.
EMPLOYEES REPRESENTED
BY

THE UNITED GAS WORKERS' UNION,
LOCAL 69,
UWUA, AFL-CIO

INTRODUCTION

To help protect you and your family against a significant impact in the event of injuries and illnesses, Eastern Gas Transmission and Storage, Inc. (the "Company") offers employees represented by the United Gas Workers' Union Local 69, UWUA, AFL-CIO the option to choose from three Medical Plan Options. As a Company employee, your medical coverage will be offered as a component program under the MidAmerican Energy Company Welfare Benefit Plan for Locals 69, 109, 499, 499 Fort Madison, and 738 Represented Employees and your retiree medical coverage, as applicable, will be offered as a component program under the BHE Pipeline Group, LLC Retiree Health and Welfare Plan. You may also waive medical coverage.

The Summary Plan Description ("SPD") for the Medical Plan consists of the following: this document and the "Additional Information" Summary Plan Description document that the Company distributes or makes available to you. Except as otherwise provided, if any term of the plan document or this document conflicts with the terms of the insurance certificate, then the terms of the insurance certificate will control, unless superseded by applicable law.

Benefits described in this document are current as of the date indicated at the bottom of the page. The Company may subsequently provide additional materials that supplement, update or amend the SPDs which will provide you with information regarding changes to your benefits.

You and the Company share the cost of providing medical coverage for you and the eligible members of your family. In most cases, you also share in the cost of medical treatments or services that are actually received. And, you and the Company share the responsibility for ensuring that medical care dollars are spent wisely.

Please note that the terms "you" and "your" throughout this SPD refer to the employee, except where otherwise indicated.

TABLE OF CONTENTS

Page

ELIGIBILITY

Full-time employees of the Company who are represented by The United Gas Workers' Union Local 69, UWUA, AFL-CIO are eligible to enroll for medical coverage. You may also enroll your eligible dependents. Eligible dependents include your:

- **Spouse**, the person to whom you are legally married.
- **Children**, regardless of marital status, (defined as your natural children, legally adopted children, children placed with you for legal adoption, foster children and stepchildren) who are under age 26.
- **Disabled children** age 26 or older, provided:
    - o they became disabled before age 26;
    - o they were enrolled in the Medical Plan at the time they became disabled (or, in the case of a newly-hired employee with a child that is already disabled, the child was covered under the previous employer's medical plan immediately prior to being covered under the Company's Medical Plan and is enrolled immediately upon the employee's employment);
    - o they remain continuously enrolled in the Medical Plan following the disability; **and**
    - o they qualify as your dependent for tax purposes (i.e., you can claim them as dependents on your federal income tax return for the year).*

  For this purpose, "disabled" means permanently and totally disabled by Social Security Administration standards applicable to children, which generally means that the child is very seriously limited in his or her activities by reason of a medically determinable physical or mental impairment that can be expected to result in death or to last for at least 12 months. Employees may be required from time to time to provide proof of the child's continuing disability.
- **Legal wards** up to age 26 for whom you are appointed legal guardian or legal custodian, provided that they qualify 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 tax dependents under the Plan.

*It is your responsibility to ensure that your disabled child or legal ward qualifies as your dependent for tax purposes before enrolling or continuing to enroll him or her in the Medical Plan. For a detailed explanation of the requirements for tax dependent status, see Internal Revenue Service (IRS) Publication 17, Your Federal Income Tax, available at www.irs.gov.

Domestic Partner:
You may also enroll your domestic partner on an after-tax basis. You pay the full cost of coverage for your domestic partner. There is no Company subsidy toward the cost of this coverage. An employee may cover another person as a domestic partner if both the employee 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)
- 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 is not limited to, marriage certificates, birth certificates, adoption certificates and federal tax returns. Lack of response to a 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 coverage from six categories of coverage. The coverage categories are:

- Employee Only
- Employee and Spouse
- Employee and Child(ren)
- Employee and Family
- Employee and Domestic Partner
- Employee and Child(ren) and Domestic Partner

EMPLOYEE SPOUSES/DOMESTIC PARTNERS
If you and your spouse or domestic partner are both employed by the Company, Berkshire Hathaway Energy Company or any of its affiliates/subsidiaries, you cannot be covered as both an employee and a dependent under a medical plan sponsored by the Company or its affiliates. Also, your children cannot be covered by both parents. When enrolling, you have two options:

- One spouse/domestic partner can sign up for coverage with the other as a dependent; or
- Both you and your spouse or domestic partner can sign up for coverage separately (with only one individual enrolling eligible children as dependents).

You may choose to waive medical coverage. If you waive coverage, you will not be able to enroll in Company-sponsored healthcare coverage until the next annual Open Enrollment, unless you experience a Qualifying Life Event.

ENROLLMENT

NEW HIRE
Your first day of work with the Company is your employment date. You can enroll in medical coverage at that time.

- If you enroll within 31 *days* following your employment date, coverage will start on your employment date
- If you do not enroll within 31 days following your employment date, you will not be able to 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 DomNet once you’ve logged on to your computer at work.
    - From the DomNet homepage, select the “Your Benefits Resources” link in the “Key Company Links” section to link directly to your YBR account via single sign-on. First time users: 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.

Remember, the benefits you elect stay in effect for the whole year.

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 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, newborn children, new stepchildren/domestic partners n, newly adopted children, and children newly placed with you for adoption.

An event will be 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 may be 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
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 ("QMCSO")	• Add child(ren) required by QMCSO (if you are not enrolled, you will also be enrolled at this time) • Change Medical Options if required by QMCSO	• Drop child(ren) if QMCSO requires spouse to provide coverage (and spouse does so) • Drop child(ren) if QMCSO terminates or expires
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

Event	Enrollments Permitted	Cancellations Permitted
Domestic partner's change in employment or benefit eligibility status***	• Add domestic partner who lost coverage under their employer's plan (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
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

Event	Enrollments Permitted	Cancellations Permitted
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		
Marriage	• Add spouse and children (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

Event	Enrollments Permitted	Cancellations Permitted
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 governing Qualifying Life Events will be interpreted and administered in accordance with IRS rules and regulations in a nondiscriminatory manner.
**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.
****A special 60-day notice/enrollment period applies to these events, rather than the 31-day period described below.

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

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

Qualifying Life Event changes take effect as follows:

- Adding coverage – coverage begins 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 will be effective the following January 1.

REHIRE/REINSTATE
Solely to the extent required under IRS regulations, if you terminate employment with the Company and return to work for the Company in an eligible category for benefits enrollment, your benefit enrollment election depends on the number of days you did not work for the Company:

- 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 benefit election(s) that changed, if another benefit election 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 the Company share the cost of your medical coverage. The Company contributes a significant share of the cost. You pay your share through payroll contributions, deductibles and copays. Employee

contributions are pre-tax for coverage categories of You Only, You + Child, You + Spouse/Domestic Partner, 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. Employee contributions for Domestic Partner coverage are on an after-tax basis, and are in addition to the employee pre-tax contributions.

The amount of your contributions depends on which Medical Plan Option you select and your coverage category (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

Employees can choose from three Medical Plan Options listed below.

- Medical Plan Option A*
- Medical Plan Option B
- Medical Plan Option C

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

Participants who receive retiree medical coverage under the Retiree Plan automatically receive a modified version of Option C. See the section of this SPD entitled "Retiree Medical Eligibility" for more details on how Option C applies to the Retiree Plan.

OPTIONS A, B, AND C

All three Options are alike in the following:

- Cover the same medical services and supplies, including in-network preventive care coverage
- Have the same Anthem Blue Cross Blue Shield ("Anthem" or "Blue Cross Blue Shield") PPO national network of doctors, hospitals and providers
- 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
- 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 will be sent a Medical Identification Card (ID): one card if you enrolled in "employee only" coverage, or two cards if you enrolled in any other category. The ID card signifies that you are covered by the PPO Plan. 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 the Company 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 will 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. Participants 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 will 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 website at www.anthem.com by selecting 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 to have the out-of-network services authorized for the highest level of benefits.

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 – BLUECARD WORLDWIDE

Prior to travel outside the United States, call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we recommend:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your current Identification Card.
- In an emergency, go directly to the nearest Hospital.
- The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at 1-800-810-BLUE (2583) or by calling collect at 804-673-1177. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Physician or Hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.
- You need to be hospitalized or need inpatient care. After calling the Service Center, you must also call the Claims Administrator to obtain approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.
- Non-emergency care of chronic illnesses received outside of the United States is not covered.

Payment Information

- Participating BlueCard Worldwide Hospitals. In most cases, when you make arrangements for hospitalization through BlueCard Worldwide, you should not need to pay upfront for inpatient care at participating BlueCard Worldwide hospitals except for the Out-of-Pocket costs (non-Covered Services, Deductible and Copayments) you normally pay. The Hospital should submit your claim on your behalf.
- Doctors and/or non-participating Hospitals. You will need to pay upfront for outpatient services, care received from a Doctor, and inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your hospitalization. You will need to pay the Hospital for the Out-of-Pocket costs you normally pay.
- You must file the claim for outpatient and Physician care, or inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the provider and subsequently send an international claim form with the original bills to the Claims Administrator.

Claim Forms

International claim forms are available from the Claims Administrator, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for submitting claims is 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.

Participants who receive in-network services are not responsible for paying the difference between the network allowance and the provider's charges. The participant's copayment amount is based on the network allowance. Therefore, the provider's charges that are in excess of the network allowance would not apply to the participant's deductible and out-of-pocket maximums.

For participants who receive covered services from out-of-network providers, the Plan will pay 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 the deductible or out-of-pocket maximum.

DEDUCTIBLE
The deductible is the amount of covered expenses you must pay each year before the Medical 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 deductible
apply to your out-of-pocket maximum. Under all three Medical Plan Options, there is no deductible for in-network preventive care.

Under **Option A** there is one deductible amount for You Only coverage and another deductible amount for all other coverage levels. 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).

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 his or her individual deductible in any calendar year.

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.

For out-of-network services, once the deductible is satisfied, you and the Plan each pay a percentage of the covered, allowable charges for medical care and treatment.

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

OUT-OF-POCKET MAXIMUM
When you satisfy the deductible and the maximum coinsurance amount, you have reached your out-of-pocket maximum. After this point, the Plan will pay 100% of allowable charges for covered 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 his or her 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. Also, the amounts you pay towards your deductible and copayments for covered services apply to the out-of-pocket maximum.

INDEXING
The deductibles and out-of-pocket maximums for both the medical and prescription drug benefits will be adjusted each year based on the increase in the Medical Consumer Price Index. Increases will be limited to 5% per year.

LIFETIME MAXIMUM BENEFIT
There is no lifetime maximum benefit under the Medical Plan.

SUMMARY OF BENEFITS

This chart compares the key features of the Medical Plan Options. The dollar amounts shown are those in effect for 2021 and will be indexed for future years.

	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	$2,019		$1,141		$569	
• Employee and dependent coverage (including domestic partners)						
- Per person	N/A*		$1,141		$569	
- Per family	$4,038		$2,282		$1,138	
Participant copayment (what you pay after the deductible for most covered care):						
• Medical care and services, including mental health and chiropractic**	20%	40%	20%	40%	20%	40%
• Office visits, including mental health and chiropractic** (See Preventive Care Coverage section)	20%	40%	20%	40%	20%	40%
• LiveHealth Online (covered only where consultation/prescription is allowed)	No cost in 2021	N/A	No cost in 2021	N/A	No cost in 2021	N/A
Annual medical out-of-pocket maximums***:						
• Employee only coverage	$4,657	$9,314	$4,569	$7,995	$2,284	$3,997
• Employee and dependent coverage (including domestic partners)						
-Per person	$6,850	$13,700	$4,569	$7,995	$2,284	$3,997
-Per family	$9,314	$18,628	$9,138	$15,990	$4,568	$7,994
Emergency Room copayment	After the deductible, you pay 20%	After the deductible, you pay 40%	You pay a $100 copay per visit plus 20% of the remaining charge after the deductible under Options B and C			
• Copayment waived if admitted to hospital						
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 pays 100% for covered prescriptions for the remainder of the calendar year.		*Administered by Express Scripts* • After you meet $81 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 $1,010 annual per person prescription drug out-of-pocket maximum***, the Plan pays 100% of that			

		person's covered prescription costs for the rest of the calendar year. • All specialty drugs must be filled by Accredo, Express Scripts' specialty pharmacy, after one fill at a retail pharmacy. Specialty drugs are dispensed for up to a 30-day supply, and are subject to the retail pharmacy copayment.
Employee contribution rate:	Lowest contribution rate ⟶ Highest contribution rate	
Health Savings Account (HSA) available	Yes – funded by automatic Company contributions and additional voluntary pre-tax contributions from you	No
Healthcare FSA available	No	Yes – funded by voluntary pre-tax contributions from you

*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 $6,850 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 $9,314 before the Plan pays 100% for all family members.
**Chiropractic is limited to 20 visits per person per calendar 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.

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:

The Company will make 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 Company HSA contribution in January or start making your own HSA contributions in January. Otherwise, due to IRS rules, all contributions (yours and the Company's) 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 (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.

Account balances earn interest. You can invest in mutual funds by contacting HSA Bank directly at 1-800-357-6246 for details.

There are some fees associated with your HSA account. The Company will pay 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, the Company will no longer pay the monthly maintenance fee. This fee will only be covered by the Company 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.

	Company contributions:	You can add up to:	Total Contribution (from the Company and you)
You only or You + domestic partner coverage	Up to $500 per year	Up to $3,100 per year	Up to $3,600 per year
You + spouse or You + Family coverage (employee + dependents)	Up to $1,000 per year	Up to $6,200 per year	Up to $7,200 per year

In addition to the limits shown in the chart above, 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 an additional $1,000 in 2021.

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 didn't 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 may also withdraw money for other reasons, but taxes and penalties may apply.
- You can take the HSA with you if you leave the Company 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 contribution amount during the year. To make a change to your HSA contribution, you must contact the Dominion Energy Benefit Center at 1-877-434-6996.

- You cannot use the HSA for domestic partner expenses or expenses of children who do not qualify as your dependent for tax purposes.
- If you enroll in Option A, because of government rules that apply to HSAs, you may not participate in a Healthcare FSA.

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, a healthcare FSA, a HRA, or coverage under a spouse's plan including an FSA or HRA through your spouse's employer. If you receive contributions to an HSA while you have other 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 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 the Company's) would be limited to 5/12 of $7,200 (or, $3,000) for family coverage for 2021. 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 an 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 the Company'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. Note that this rule merely delays, but does not reduce, the total amount of annual HSA contributions you receive (yours and the Company's).

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:

	Option A	**Options B and C**
Who can enroll	Any eligible employee and eligible dependents. But you cannot receive any HSA contributions (yours or the Company'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.	There are individual and family annual deductibles. The Plan begins to pay expenses for an individual when: • He/she meets 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	There are individual and family annual out-of-pocket maximums. The Plan begins to pay covered expenses at 100% when:

	Option A	Options B and C
	begins to pay covered expenses at 100% **when:** ▪ **He/she meets the individual out-of-pocket maximum; or** ▪ The family's combined expenses meet the family out-of-pocket maximum.	▪ He/she meets the individual out-of-pocket maximum; or ▪ The family's combined expenses meet the family out-of-pocket maximum.
Prescription drugs	• Administered by Anthem and Express Scripts • Covered after you meet annual deductible -- $2,019 if you have employee only coverage or $4,038 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. • 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 $81 per person. • Copayment percentages based on type of drug: generic, formulary or non-formulary. • After $1,010 per person out-of-pocket prescription drug maximum, 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 Company contribution and opportunity to contribute yourself – for combined contribution up to - $3,600 a year if you have employee only coverage. - $7,200 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 the Company, you may take your HSA balance with you. • 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 (FSA) --- administered by PayFlex • No Company contribution. • You have the opportunity to contribute up to $2,750 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 the Company, you may use your remaining FSA account balance - for services that occurred while you were at the Company. - for services the rest of the calendar year by continuing your FSA coverage through COBRA. • 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.

PREVENTIVE CARE

Preventive care is an important part of keeping you and your family healthy and helping the Company to control future benefits costs. All three Medical Plan Options offer the same preventive care benefits – without having to meet the deductible – as long as you use a network provider. Note: 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 details see Covered Services section; "Preventive Care Services."

Preventive care services for covered members age 7 and older include:

Service	Participant Copayment	Comments
• Annual checkup office visit • Annual gynecological exam and Pap test • Annual prostate exam and PSA test for men age 40 and older • Annual mammogram for women age 35 and older* • Annual colorectal cancer screening* • Routine tests, lab and x-ray services associated with an annual check-up, gynecological or prostate exam	$0	Once per calendar year.
Immunizations	$0	Covers immunizations to prevent or reduce the risk of conditions such as tetanus, flu and human papillomavirus (HPV). Some immunizations require prior approval. Covered immunizations may be purchased in or out-of-network under both Anthem and Express Scripts. *Note: You need to file a paper claim with Anthem for out-of-network services.*
• Women's contraceptives, sterilization procedures, and counseling. Coverage 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.	$0	
*The Medical Plan will pay 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 will be covered under the Plan's preventive care program, confirm with Anthem Customer Service at 1-800-348-1966 prior to having the service performed.

ADDITIONAL PREVENTIVE CARE BENEFITS UNDER THE AFFORDABLE CARE ACT

In addition, all three Medical Plan 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. A full list of these benefits is available here: http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html. The Medical Plan Options interpret and apply this list consistent with the Affordable Care Act. Please note that, consistent with the Affordable Care Act, this paragraph does not apply to Retiree Medical Plan coverage.

CONDITION MANAGEMENT

The Medical Plan (all three Options) offers a Condition Management program called Anthem MyHealth Advantage. This free program assists in managing medical conditions, medications, routine tests and checkups, 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 1-800-700-9184.

BEST DOCTORS

If you or a family member are diagnosed with a serious health condition or your doctor recommends a complex or expensive medical treatment, Best Doctors can provide you with an expert second opinion. When you contact Best Doctors, an expert specializing in your condition will check the accuracy of your diagnosis and make recommendations. Contact Best Doctors at https://members.bestdoctors.com or call 1-866-904-0910.

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. And, 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 the Company's health plan. There is no cost in 2021 as part of the COVID benefits.

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.

COVERED SERVICES

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 just for the convenience of the patient, patient's family, or the provider.

Just because a service is prescribed by a provider, it 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.

Breast reconstruction benefits: participants who 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 other breast to produce a symmetrical appearance, prostheses and physical complications of mastectomy, including lymphedema. Covered services will be provided in a manner determined in consultation between the attending physician and the patient. Benefits will be 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.

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

- there is no clearly superior, non investigational treatment alternative,
- there is a reasonable expectation that the treatment will be at least as effective as the non investigational alternative, and
- the participation in the trial is appropriate for the employee/family member.
    - The clinical trials must be approved by National Cancer Institute (or NCI designated facility), the FDA or the Department of Veterans Affairs.

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: 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; and dental services to prepare the mouth for radiation therapy to treat head and neck cancer. Information about coverage for impacted wisdom teeth can be found under Surgery.

Diabetic supplies, and equipment: medical supplies, and equipment for diabetes care for all diabetics. This includes insulin pumps; home glucose blood monitors; hypodermic needles and syringes. Diabetic supplies are covered under the prescription drug benefit. Also covered under the Plan is: Outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin-using diabetes, if provided by a certified, registered or licensed health care professional with expertise in diabetes.

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, ultrasound or nuclear medicine; laboratory and pathology services or tests; and diagnostic EKGs, EEGs. 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); your doctors' or other covered professional providers' visits during an inpatient hospital stay; surgeon's services, which include operative or cutting procedures, treatment of fractures and dislocations, and endoscopic or diagnostic procedures; inpatient care by two or more professional providers at the same time because of the severity of your illness; and consultation by another doctor when the inpatient services of the attending doctor are covered.

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 as eligible under part H 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. 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.

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.

Hearing aids and associated hearing exams and routine hearing care: 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: if you are homebound (meaning your condition confines you to your home except for short, infrequent absences), treatment provided by a home health care agency in your home including: visits by a nurse, therapist, or home health aide; special outpatient treatments when medical equipment cannot be brought to the home; services of a certified home health aide for personal care (if provided at the direction of a registered nurse), including helping you walk, dress, bathe, assisting you with medicine, and teaching you self-help skills; supplies normally used in the hospital (for example, needles, dressings, oxygen, or IV fluids); physical, speech, hearing, respiratory, and occupational therapy; and services of a licensed clinical social worker. To ensure benefits, your doctor must provide a description of the treatment you will receive at home. To receive home health care services, the Plan of care must be preauthorized. Your doctor must certify that these home health care services are medically necessary for your condition, and not merely custodial in nature.

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: a program of home and inpatient care provided directly by or under the direction of a licensed hospice, 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; 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 will change 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 will be 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. All inpatient hospital stays must be approved before each admission (see “Hospital Admission Review” in this section). Non-medically-necessary hospital stays are not covered by the Plan.

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 (or your covered dependent) 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. Remember to call or have your doctor call to notify Anthem of your hospital inpatient admission. You may notify Anthem as much as three months before delivery. 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 your doctor submits one bill for delivery, prenatal, and postnatal care services, payment will be made at the same level as inpatient professional provider services. If your doctor bills for these services separately, your payment responsibility will be determined by the services received.

The Plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this 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 in cases of cesarean section). These provisions are in compliance with the Newborns' and Mothers Health Protection Act of 1996.

You (or your covered dependent) 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 will 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.

Medical equipment: the rental (or purchase if that would be less expensive) of durable medical equipment required for therapeutic use when prescribed by your doctor including the following types of equipment: renal dialysis machines; respirators; 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; arm braces, back braces, and neck braces; surgical supporters; head halters; and splints.

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 provided by your doctor.

Mental health and substance abuse services:

- Inpatient care for mental health 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. To be covered, the substance abuse treatment facility must be licensed to provide a continuous, structured, 24-hour-a-day plan of bed patient drug or alcohol treatment and rehabilitation. As an alternative to inpatient psychiatric treatment, your physician can recommend "partial day" mental health services. A partial day program must be licensed or approved by the state and must include either a day or evening treatment program, which lasts at least 6 or more continuous hours per day for mental health or substance abuse, or an intensive outpatient program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence. The availability of benefits for partial day services is subject to the results of your Hospital Admission Review.
- Outpatient mental health services cover the diagnosis and treatment of psychiatric conditions and include individual psychotherapy, group psychotherapy, and psychological testing. Substance abuse treatments must occur through a licensed intensive care outpatient provider for the treatment of alcohol or drug dependence. 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.

Prescription drugs: prescription drugs are medicines, including insulin, 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 plans cover eligible prescription drugs if received through a pharmacy, a doctor's office, or a hospital. Also covered are prescription drugs approved by the Food and Drug Administration (FDA) for use as contraceptives. 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.

The following details how the program works:

- 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 doctor 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.*

Formulary – A formulary is a list of preferred prescription drugs. It is created, reviewed and updated by a team of doctors and pharmacists at Express Scripts. The formulary contains a wide range of generic and brand name drugs that have been approved by the U.S. Food and Drug Administration (FDA). Formulary drugs are selected because they are safe, effective and they save money. 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 mail. 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 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, after the 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. Specialty drugs are dispensed for up to a 30-day supply and are subject to the retail pharmacy copayment.

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. Step therapy requires that one or more generic or other brand-name medication is taken before the prescribed medication. These medications are not only effective, they are generally the least costly to you.

- The 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 requirement, contact Express Scripts at 855-621-9184 or visit their website 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 800-753-2851. If your request is approved, your doctor will be notified. An approval code is provided to the pharmacist for the claim to be processed. You will need to 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.

The Plan will not deny prescription drugs (or inpatient or IV therapy drugs) used in the treatment of cancer pain on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.

Network pharmacies. Your prescription drug card benefits cover prescriptions obtained from a pharmacist. You may receive up to a 30-day supply (60-day supply under Option A) of medicine for an original prescription and refills for up to one year. Simply choose a pharmacy that participates in the Express Scripts Pharmacy Network and show your ID card to receive benefits. To find a pharmacy that participates in the Express Scripts Pharmacy Network you can refer to the Express Scripts directory of network providers which lists participating pharmacies; check with your local pharmacy to see if they participate in the Express Scripts Pharmacy Network; or call Express Scripts. Express Scripts Pharmacy Network pharmacies, available nationwide, will automatically file claims for you and charge you only the required coinsurance amount under your health care plan for covered prescriptions. You must have used 75% of your prescription before it can be refilled. However, in the following circumstances, you can obtain an additional 30-day (60-day for Option A) supply from your pharmacist: you've lost your medication; you're going out of town for up to one month; or your physician increases the amount of your dosage.

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. You may also purchase your maintenance medication through the mail and have your prescription delivered directly to your home. To receive your maintenance medicine by mail, ask your doctor to send the prescription electronically or to call 1-888-327-9791 for instructions on how to fax the prescription. Your doctor must have your member ID number (which is on your member ID card) to fax your prescription. Note: only prescriptions faxed from a doctor's office are accepted).
You may also mail the prescription to Express Scripts by following these 2 steps:

1) 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 and another to send to the Express Scripts Mail Service Pharmacy.
2) Mail your original prescription(s), the completed mail order form and a check to cover the amount of your copayment(s) to the home delivery pharmacy. You may charge your copayment with a major credit card by completing the needed information on the mail order form.

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

- Mail your order form to:

  Express Scripts
  Home Delivery Service
  PO Box 66577
  St. Louis, MO 63166-6577

You may also request refills and reimbursement forms by calling Express Scripts at 855-621-9184 or by visiting their Web site at www.express-scripts.com.

Filing claims. You may need to file your own claim if you need to have a prescription filled before you receive your card 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 web site at www.express-scripts.com. To file a claim, follow these 3 steps:

1) Complete the *Prescription Drug Reimbursement Form*. If possible, ask the pharmacist to complete the pharmacy section of the form and sign.
2) Pay for the prescription.
3) Mail your claim form to the address on the form.

Minimum Copays under **Options B and C**. The following details how the minimum copays work:

- If the total cost of the drug is under the minimum dollar amount, you pay the total cost of the drug.
- If the copay percentage amount is under the minimum dollar amount, you pay the minimum.
- If the copay percentage amount is higher than the minimum dollar amount, you pay the percentage amount.

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, and other immunizations as may be prescribed by the Commissioner of Health; and certain laboratory and screening tests, including infant hearing and vision tests. The American Academy of Pediatrics recommends the following schedule for well child care visits:

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

The Plan also provides coverage for routine immunizations and tests (including lab work and x-rays) for each covered participant.

- **Routine preventive care:** for covered members age 7 and older, in-network benefits are provided for:
  - Office visit for annual checkup
  - Annual gynecological exam and pap smear performed by any FDA-approved gynecologic cytology screening technologies
  - Annual mammogram for women age 35 and older
  - Annual colorectal cancer screening such as an annual fecal occult blood test; flexible sigmoidoscopy; colonoscopy; or barium enema. These services will be 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 for men age 40 and older
  - 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.
  - Routine tests, lab and x-ray services billed with annual check-up/exam, and/or GYN exam.

  NOTE: Preventive care 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.

Shots (Injections): therapeutic injections (shots) that a provider gives to treat illness or pregnancy-related conditions (e.g., allergy shots). Immunizations and self-administered injections are not therapeutic injections.

Skilled nursing facility: inpatient services and supplies for skilled nursing home stays as described in "Hospital Services" in this section. 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.

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.

- **Morbid obesity:** treatment of morbid obesity through gastric bypass, or other methods recognized by the National Institutes of Health (NIH). Coverage is restricted to surgical procedures and does not include weight control dietary supplements. According to the NIH guidelines, gastric bypass surgery is effective for the long-term reversal of morbid obesity for a patient who: weighs at least 100 pounds over or twice the ideal body weight; has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or has a body mass index of 40 kilograms per meter squared without such comorbidity.

- **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 in the presence of severe handicapping malocclusion; 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.

- **Organ and tissue transplants, transfusions:** the Plan covers some but not all organ and tissue transplants. When a human organ or tissue transplant is provided from a living donor to a covered member, and both the recipient and the donor are covered by the Medical Plan, both may receive the benefits of the Plan. When only the recipient is covered by this health plan, the donor's benefits are limited to those not available from any other source (including other insurance coverage, other Blue Cross Blue Shield coverage, or any government program). When only the donor is covered by this health plan, the donor's benefits are also limited to those not available from any other source (including other insurance coverage, other Blue Cross Blue Shield coverage, or any government program). The following major organ and tissue transplants and any medical complications from such services are the only organ and tissue transplant services covered by your plan: autologous parathyroid transplant; blood transfusion; bone and cartilage grafting; corneal transplant; heart or heart-lung transplant; kidney transplant; liver transplant or liver lobe; pancreas transplant; pancreas and kidney combined transplant; single or double lung or lobe transplant; skin grafting; and small bowel or small bowel transplant and liver transplant.

Therapy: includes physical, occupational, speech, and respiratory therapy when the treatment is medically necessary for your condition and provided by a licensed therapist. The Plan also covers chemotherapy treatment of malignant disease by chemical or biological antineoplastic agents. However, oral chemotherapy is covered only if the drug used requires a doctor's written prescription and is covered under your prescription drug benefit. High dose chemotherapy and/or high dose radiation, as well as any supporting allogeneic or syngeneic bone marrow transplants or other forms of allogeneic or syngeneic stem cell rescue, will be covered by the Medical Plan when used to treat specified conditions. A list of these conditions is available from Anthem. Also covered are:

- **Infusion therapy** treatment by placing therapeutic agents into the vein, including intravenous feeding. This also includes enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract.
- **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.
- **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.
- **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 will be 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 PPO 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 treatment or service.*

This list of services and supplies that are excluded from coverage by your health plan will not be covered in any case.

- **Acupuncture.**

- **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 or natural teeth due to accidental injury for which a treatment plan was not submitted to anthem within 60 days of your date of injury.
  - 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.

- **Donor** searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, child, sibling).

- **Educational** or teacher services except in limited circumstances.

- **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.

- Services for palliative or cosmetic **foot** care including:
  - flat foot conditions;
  - support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;
  - foot orthotics;
  - subluxations of the foot;
  - corns;
  - bunions (except capsular or bone surgery);
  - calluses;
  - care of toenails;
  - fallen arches;
  - weak feet;
  - chronic foot strain; or
  - symptomatic complaints of the feet.

- The following **home care** services:
  - homemaker services;
  - maintenance therapy;
  - food and home delivered meals; or
  - custodial care and services.

- 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.

- **Medical equipment, 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 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; or
  - 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 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. The exception is morbid obesity. Coverage is provided for treatment of morbid obesity through gastric bypass surgery or other methods recognized by the National Institutes of Health (NIH) as effective treatment for the long-term reversal of morbid obesity for a patient who:
  - weighs at least 100 pounds over or twice the ideal body weight;
  - has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
  - has a body mass index of 40 kilograms per metered squared without such comorbidity.

- Benefits for **organ or tissue transplants,** including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only 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.

- **Organ or tissue transplants**, including complications caused by them, except for the following:
  - autologous parathyroid transplants;
  - autologous islet cell transplant;
  - blood transfusions;
  - bone and cartilage grafting; and

- corneal transplants;
- kidney transplant;
- heart or heart-lung transplant;
- liver transplant or liver lobe;
- pancreas transplant;
- pancreas and kidney combined transplant;
- single or double lung or transplant of lobe
- skin grafting; or
- small bowel or small bowel transplant and liver transplant.

- **Paternity testing.**

- **Prescription drug program** does not include coverage for the following:
  - 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 approved by the FDA in the treatment of certain conditions
  - smoking cessation aids;
  - therapeutic devices or appliances;
  - injectable prescription drugs that are supplied by a provider other than a licensed pharmacy;
  - 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, LLC (MCMC), the company that independently reviews claim decisions;
  - medicine furnished by any other drug or medical service;
  - Erectile dysfunction drugs;
  - Medication for sex transformation;
  - Hair growth stimulants;
  - Non-legend vitamins and minerals;
  - Nutritional supplements (including over-the-counter and prescription items) for providing complete or supplemental nutritional support
  - Allergens and serums;
  - 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; or
  - Syringes other than insulin.
  - Drugs that are excluded from the formulary, and are not covered as a non-formulary drug, as determined by the prescription drug Claim Administrator or any third party reviewer, such as MCMC; or
  - Certain compound drugs as determined by Express Scripts, the prescription drug Claims Administrator.

- **Private duty nurses** in the inpatient setting.

- Rest cures, **residential** or domiciliary care and services. Whether care is considered residential will be 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.

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

- Care from institutions or facilities that are licensed based solely as **residential treatments** centers, intermediate care facilities, or other non—skilled sub-acute inpatient settings.

- **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;
  - not listed or described as covered services under your health plan;
  - not prescribed, performed, or directed by a provider licensed to do so;
  - received before the effective date or after a covered person's coverage ends;
  - telephone consultations, charges for not keeping appointments, or charges for completing claim forms;
  - for travel, whether or not recommended by a physician;
  - given by a member of the covered person's 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 policy plan have been paid. The Plan will pay 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. This exclusion does not apply to health benefits plans offered for civilian employees or retired civilian employees of the federal or state government;
  - received from an employer mutual association, trust, or a labor union's dental or medical department; or
  - for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

- **Services** for which a charge is not usually made. This includes services for which you the Member 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.

- Benefits for services related to **smoking cessation**, including stop smoking aids or services of stop smoking clinics.

- **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; physical therapy; 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 nearsightedness 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
  - radial keratotomy and any surgical procedures to correct nearsightedness or farsightedness. This type of surgery includes keratoplasty and lasik procedures;
  - services for vision training and orthopics; 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 regulations to provide benefits to the Member 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 the covered person reaches a settlement with his or her 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. Non-medically-necessary inpatient stays 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 1-804-359-7277 or 1-800-242-7277. 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 will 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 covered radical or modified radical mastectomy for the treatment of breast cancer will 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, your doctors, and your employer 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

Coordination of benefits (COB) occurs when you have medical coverage through the Company Medical Plan and another group medical plan.

Under the coordination of benefits provision of each of the three Medical Plan Options, benefits from your Medical Plan and any other plan will be coordinated so that the benefits from both plans will not exceed the benefit that would be payable from the Company Medical Plan if it were the primary plan.

If you are covered by one of the three Medical Plan Options, it will be considered your primary coverage and will pay benefits first for your medical expenses. Any alternate coverage you have will be considered secondary and will pay benefits second.

If your spouse or domestic partner is also working and has coverage through his or her employer, that coverage will be the primary coverage for your spouse or domestic partner and will pay benefits first for his or her expenses. Coverage under the Company Medical Plan will be considered secondary and will pay benefits after the primary carrier pays their benefit. The amount paid by the Company Medical Plan and the primary plan combined will not exceed the benefit that would be paid by the Company Medical Plan if it were the primary payer.

If your other covered dependents are also covered by your spouse’s or domestic partner’s plan, the Company Medical Plan will be considered the primary plan for them if your birthday is earlier in the year than your spouse’s or domestic partner’s. If you and your spouse or domestic partner share the same birthday, the Company Medical Plan will be the primary plan if your coverage under the Company Medical Plan has been in effect longer than your spouse’s or domestic partner’s coverage under the other plan.

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.

If you or a covered dependent is also covered by Medicare while you are an active employee, your Company Medical Plan will be primary; Medicare will be secondary. This policy assures that no one receives more than the benefits payable from the Plan if no other coverage was in place.

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 a Company Medical Plan, Medicare is generally your primary coverage and the Company Medical Plan is secondary. This means Medicare will pay benefits first, then your remaining expenses will be considered for reimbursement under the Company Medical Plan. Your claim will always be paid as if you are receiving any Medicare benefits for which you are eligible, even if you are not actually enrolled.

However, if you or a covered dependent were covered under Medicare on or after February 1, 1996, solely because of end stage renal (kidney) disease, then your Company Medical Plan will continue to be your (or your covered dependent's) primary coverage for the first 30 months. After this time period, Medicare becomes your primary source of coverage.

You will be asked periodically to provide information about your other coverage. Failure to provide this information could result in a denial of benefits.

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 will be required to cooperate with Anthem to secure this right.

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 your responsibility to make sure 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 or a covered family member 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 27287, Richmond, VA 23261.

You can obtain a medical claim form on DomNet, or by calling Anthem Customer Service at 1-800-348-1966, or the Dominion Energy HelpLine at 1-877-947-4636.

BALANCE BILLING

When you receive care and/or treatment from an out-of-network provider and you have no choice in selecting that provider, the Plan Administrator can request Anthem to review your claim. For example,

you use a network hospital and a network surgeon, but the anesthesiologist does not participate in the network. You can contact Anthem and request that they review your claim. You need to provide the patient's name, date of service, name of the provider and the type of service being billed. If Anthem determines you had no choice in selecting the out-of-network provider, the Plan Administrator has Anthem reprocess the claim at the in-network benefit level based at the billed amount (vs. the allowable charge). You are responsible for your copay amount (including the deductible).

APPEAL AND REVIEW PROCESS

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 both pre-service and post-service 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 other claim for benefits under the Plan for which you have received the service.

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 his or her 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; and
- 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.
- 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.). See "Notification of the Outcome of the Appeal," below, for the time frames.

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, to 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 claim involving urgent/concurrent 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 any other pre-service claim, 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.

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.

All other requests for External Review should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. Such requests 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.

This 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.

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.

Anthem 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 the Plan Administrator. 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 the Plan Administrator. 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.*

Prescription Drug Claim Appeals
You may request a review of a prescription drug claim denial in writing to Express Scripts at the following address:

> Express Scripts, Inc.
> Attention: Pharmacy Appeals
> 6625 West 78th Street, Mail Route BL0390
> Bloomington, MN 55439

Your letter should include an explanation of why you feel the denial was incorrect, along with any other information that you feel should be considered when reviewing your appeal. Be sure to include:

- the employee's name and identification number (found on your Express Scripts identification card);
- patient name;
- drug name; and
- date(s) of service.

You must file your appeal within 180 days of the date you were notified of the initial claim denial.

How Express Scripts Will Handle Your Appeal
When an appeal is received by Express Scripts, it is sent to MCMC, the company that independently reviews claim decisions. MCMC's review is conducted by a physician with appropriate training and experience who had no involvement in the previous decision. The physician(s) is selected by MCMC. Such physician(s) is employed by, or under contract with, MCMC; is not an employee of, or under contract to Express Scripts or the Plan Administrator; and is a Board–Certified physician(s).

MCMC will respond in writing to your appeal within the following timeframes:

- For pre-service claims, MCMC will respond in writing within 30 days after receipt of the request to appeal;

- For post-service claims, MCMC will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, MCMC will respond orally within 1 working day after receipt from you or your treating provider, of the request to appeal. MCMC will provide written confirmation of their decision to you and your treating provider within 24 hours thereafter.

When MCMC's review of your appeal has been completed, you will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the final decision, the reasons for the decision and references to the Plan provisions on which the decision is based. Express Scripts will receive a copy of the letter. You will have the right to receive, upon request and free of charge, copies of all documents, records and other information relevant to MCMC's determination regarding your claim for benefits, including any criteria or documents used to make the decision.

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 reach age 65 while you are still working for the Company, your coverage under the Medical Plan will be primary (i.e., will pay claims first) and Medicare will be the secondary carrier.

IF YOU BECOME DISABLED
This section provides information about continuation of your medical coverage should you be awarded long-term disability benefits under the Company's Long-Term Disability (LTD) Plan.

If you are covered under the Company Medical Plan at the time you become disabled under the Company's LTD Plan, you may continue coverage under Medical Option C at no cost to you for as long as you remain disabled under the Company's LTD Plan.

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 Company medical plan, Medicare is generally your primary coverage and the Company medical plan is secondary. This means Medicare will pay benefits first, then your remaining expenses will be considered for reimbursement under the Company Medical Plan. Your claim will always be paid as if you are receiving any Medicare benefits for which you are eligible, even if you are not actually enrolled.

However, if you or a covered dependent were covered under Medicare on or after February 1, 1996, solely because of end stage renal (kidney) disease, then the Company's Medical Plan will continue to be your (or your covered dependent's) primary coverage for the first 30 months. After this time period, Medicare becomes your primary source of coverage.

Upon your retirement, you may continue to receive coverage under Medical Plan Option C, provided you have accrued at least ten years of service (including years of service during the period of your disability), and provided that you pay the applicable premium. If you were hired by Dominion Energy Company on or before March 23, 2017 (or if you were originally hired before that date and are rehired after that date following a break in service of fewer than five years), you may be eligible for Retiree Medical Coverage.

WHEN COVERAGE ENDS

Coverage for you under the Medical Plan will continue through the last day of the month in which:

- You terminate employment with the Company;
- 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 or domestic partner and dependent children under the Plan will continue 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); or
- 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 for children who reach the age limit will cease on the last day of the month during which they attain age 26.

If you die, coverage will continue 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 “Survivor Medical Benefit” in this 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;
- The plan year 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 or dependent children, you must contact the Dominion Energy Benefit Center at 1-877-434-6996 within 31 days of the event. Based on IRS regulations, if your enrollment change is not processed within 31 days of the event when dropping a dependent, the dependent is deemed ineligible and their coverage ends, but your payroll contribution may be changed prospectively only through the end of the year.

COBRA

You and your spouse, your domestic partner or dependent children may elect to continue coverage under the Plan as provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) if the original coverage ends because of one of the following life events:

- Your termination of employment (other than for gross misconduct).
- Your retirement.
- A reduction in your hours of work to less than regular, full-time status to the extent that you no longer are eligible for coverage.
- Your disability.
- Your death (please refer to “Survivor Medical Benefit” in this section).
- Your divorce (final decree must be granted).

- Your child ceases to qualify for dependent coverage under the terms of the Plan.

Please refer to the "Additional Information" SPD for details regarding COBRA.

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.

OTHER CIRCUMSTANCES
If you or a dependent are hospitalized when coverage ends, the Plan will continue to pay covered expenses until the patient is discharged from the hospital or exceeds Plan limits, whichever occurs first. You should discuss this and other situations with the Human Resources Center to determine when coverage can and cannot be extended.

RETIREE HEALTH AND WELFARE PLAN

If you were eligible to receive retiree medical benefits prior to November 1, 2020, you will receive retiree medical benefits through Dominion Energy Company.

The Company provides retiree medical benefits to eligible former employees hired or rehired by Dominion Energy Company on or before March 23, 2017 and their dependents under the BHE Pipeline Group, LLC Retiree Health and Welfare Plan (the "Retiree Medical Plan"). Employees hired by Dominion Energy Company after March 23, 2017 are not eligible for retiree medical benefits. However, retirees covered under the Retiree Medical Plan who return to active employment at the Company will be eligible for retiree medical benefits when they subsequently terminate employment.

Retiree Medical Coverage
The Company provides medical benefits to you and your eligible dependents under the Retiree Medical Plan during your retirement. You are eligible to participate in this retiree medical coverage if you:

- Have not met the retiree medical eligibility requirements prior to November 1, 2020;
- Were hired or rehired by the Dominion Energy Company on or before March 23, 2017;
- Are at least age 55 (58 effective April 1, 2023) at the time you retire from active employment with the Company;
- Retire from active employment with the Company; and
- Have at least 10 years of pension service at the time you retire from active employment with the Company.

If you are eligible to participate in the retiree medical coverage when you separate from the Company, you may defer enrollment in the Retiree Medical Plan and remain in "deferred status" as long as you choose. You may enroll in the Retiree Medical Plan, or other retiree medical coverage offered by the Company (if any) at a later time. While the Company anticipates making retiree medical coverage available in the future, it reserves the right to make changes to retiree medical benefits after your retirement.

When you elect Retiree Medical Plan coverage, and only at that time, you may elect to cover your spouse and/or eligible dependent children. If you do not elect Retiree Medical Plan coverage for yourself, no Retiree Medical Plan coverage is available for your spouse and/or eligible dependent children. No spouse or dependent child can be added to your Retiree Medical Plan coverage after your retirement date.

> ***Dependent Children.*** For purposes of Retiree Medical Plan 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 to 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 Company's Medical Plan at the time they became disabled (or, in the case of a newly-hired employee, they were covered under a previous employer's medical plan immediately prior to the employee's employment with the Company *and* they were enrolled in the Company's Medical Plan immediately upon the employee's employment), and (3) they remained continuously enrolled in the Company's Medical 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 Plan 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 five months during the year, **or** (iii) disabled. The child must also be younger than you, unless he or she qualifies as disabled.
  - **Residency**: The child must live with you for more than half the year.
  - **Relationship**: The child must be your natural child, stepchild, 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 his or her 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 his or her 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 spouse and eligible children may continue coverage, provided they make the required contributions. If your spouse remarries, both your spouse and children would 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.

Coverage under the Retiree Medical Plan also applies if (1) you die while in either full-time or part-time active employment with the Company or are receiving benefits under the Company LTD Plan, (2) at the time of your death, you were otherwise eligible to retire and receive benefits under the Retiree Medical Plan; and (3) your beneficiary commences the survivor pension benefit immediately upon your death. 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 will be eligible to elect medical coverage that is the similar to active employee Option C, except that under the Retiree Medical Plan, the lifetime maximum is $4,000,000, domestic partners are not eligible dependents, copayments and annual benefit maximums apply to certain preventative care benefits, and coverage for certain preventive care benefits required by the Affordable Care Act are not covered. The Company reserves the right to make changes to these benefits after your retirement. Your share of the cost of this coverage is based on your age as of January 1, 2006 and the sum of your years of pension service and age when you retire.

Coverage After Medicare Eligibility (at age 65)
In lieu of the benefits described in this SPD, the Company will provide a health reimbursement account for retiree medical participants who are over age 65. This account is funded solely by the Company and can be used to purchase health coverage on the open market to supplement your Medicare coverage. The amount of Company funding you will receive is based on your years of service, age, hire date, and retirement date. To take advantage of this benefit, you must be enrolled in Medicare Part B. For more details, please refer to the separate Retiree HRA SPD.

Your active employee medical benefits (if any) will be extended for an additional month after your retirement to ensure that you have sufficient time to enroll in HRA coverage through ViaBenefits

Coverage After Medicare Eligibility (for disabled individuals under age 65)
For participants who are not yet age 65, but who are nevertheless eligible for Medicare due to a disability, retiree medical coverage is the same as your pre-Medicare retiree medical coverage (i.e., you will be eligible for Option C), with one difference: the Plan coordinates with your Medicare coverage. 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 your retiree medical coverage.

The Company reserves the right to make changes to these benefits after your retirement.

Paying for Your Retiree Medical Coverage
The amount you pay for retiree medical coverage is, in part, based on your age at January 1, 2006 and the sum of your years of pension service and age when you retire.

Participants who have become eligible for Medicare after reaching age 65 will not pay premiums to the Company. Instead, they will pay premiums to the insurance carrier of their choice, and those premiums will be based on the coverage they have selected. The HRA provided by the Company can be used to pay for those premiums.

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

SURVIVOR MEDICAL BENEFIT

In the event of the death of a regular full-time employee, the Company provides a Survivor Medical Benefit. Medical coverage will be extended to the surviving spouse and to eligible dependent children if they were, at the time of the employee's death, covered dependents under the employee’s medical plan.

Note: If, at the time of your death, you were eligible to retire and receive benefits under the Retiree Medical Plan , your surviving spouse and eligible dependent children are provided coverage under the Retiree Medical Plan if they satisfy the requirements for enrollment in the Retiree Medical Plan. See the preceding section for details about the Retiree Medical Plan. If the Retiree Medical Plan enrollment requirements are not satisfied, your surviving spouse and eligible dependent children will be provided coverage under the Employee Medical Benefit.

ELIGIBILITY
Eligibility for Survivor Medical benefits continues for covered spouses and covered dependents until any one of the following events occurs for the employee:

- 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
- 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 the employee's death.

ENROLLMENT
The medical coverage that was in force for the spouse/dependent(s) at the time of the employee's death will automatically continue for one month following the month in which the employee dies. This additional month of coverage is provided by the Company at no cost to the spouse/dependent(s).

The eligible spouse/dependent(s) will receive information 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 Company-paid coverage.

The 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, the spouse/dependent(s) will be covered under the same Medical Plan Option that was in effect at the time of the employee's death.

COVERAGE RULES
There are a number of special coverage rules under the Survivor Medical benefit.

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 the 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 will be 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 will result in automatic termination of coverage. Payments postmarked on or before the last day of the grace period will be accepted.

Premiums are subject to change from time to time. Participants will be notified of changes.

Open Enrollment
Plan participants will be provided with an opportunity each year to change medical 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.
- 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 the employee's 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 will be required to reimburse the Company for any of its premiums and claim payments from the date coverage should have ended.

Survivor Medical Benefits or COBRA
An 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, he or she 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” SPD.

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. The spouse/dependent(s) will need to 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” section. Questions should be directed to the Dominion Energy Benefit Center at 1-877-343-6996.

SUBROGATION

The Medical Plan (all three Options) has a subrogation provision that allows the Plan to recover medical benefits paid on behalf of a covered person when the covered person is also entitled to payments for the same sickness or injury caused by a liable third party. A liable third party is another person or entity that is legally responsible for payments to the covered person (such as an automobile insurance carrier). When this situation occurs, the Medical Plan will recover the lesser of the following:

- payments made by the third party up to the amount paid by the Medical Plan; or
- the full payment made by the third party if it is less than payments made by the Medical Plan.

By filing a claim with the Medical Plan for services due to sickness or injury for which the covered person is also entitled payments by a liable third party, the participant agrees to:

- give the Medical Plan the right to recover payments, up to the full amount paid by the Plan;
- pay the Medical Plan any amount received from the third party up to the amount paid by the Medical Plan; and
- cooperate with the Medical Plan in pursuing recovery, by completing any necessary forms or documents and serving as a witness in court proceedings if needed.

If you, the employee, fail to comply with the subrogation policy and procedures, medical coverage for you and all covered dependents will be suspended effective the end of the month you are notified

If your covered dependents fail to comply with subrogation, the Plan will suspend medical coverage for those dependents at the end of the month you are notified. If your covered dependents have not complied with subrogation by December 31 of the year in their coverage was suspended, coverage for you and your dependents will be cancelled effective the following January 1.

Claims incurred during the period of suspension will not be covered by the Plan.

Medical coverage can be reinstated effective the first of the month following the date you and/or your dependents have fully complied with the subrogation policy and procedures.

Suspension of medical coverage due to noncompliance with the subrogation policy and procedures will provide the participant(s) with the opportunity to continue medical coverage under COBRA.

Once coverage has been canceled, you may apply for coverage during a subsequent Open Enrollment period if you have fully complied with the subrogation policy and procedures. Other family members may apply for coverage only if both you and they have fully complied with subrogation. Coverage will be effective the following January 1.

CHANGING OR TERMINATING THE PLAN

Please see the “Changing or Terminating the Plans” section of the “Additional Information” SPD for information on the Company’s ability to change or terminate the Medical Plan.

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 and contracts that govern the operations of the Medical Plan, those official documents and contracts will govern.