DENTAL 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

Eastern Gas Transmission and Storage, Inc. (the "Company") offers employees represented by the United Gas Workers' Union Local 69, UWUA, AFL-CIO a Dental Plan that provides coverage for checkups, cleanings and other dental services for you and your covered dependents. Your dental coverage is 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.

The Plan provides a standard level of benefits based on a portion of the reasonable and customary charges for various local areas as determined by the claims administrator. You may obtain services from any dentist and receive benefits under the standard level. In addition, some dentists participate in a network, and have agreed to discounted fees. Participants using a network dentist should not be responsible for any additional charges above the deductible and coinsurance amounts in the Plan. When you use a dentist not participating in the network, you may be responsible for additional charges. If your provider charges more than the amount allowed by the Plan, you will be responsible for the balance of the bill.

You and the Company share the cost of providing dental coverage for you and members of your family, as well as the cost for some dental services received.

> The Summary Plan Description for the Dental Plan consists of the following: this document and the "Additional Information" Summary Plan Description document that the Company distributes or makes available to you.

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.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

The following table summarizes the key features of the Dental Plan.

	COVERAGE LEVELS	
	Standard	**Network***
	Plan Pays	**Plan Pays**
Annual Deductible: $25 per individual; $75 per family		
Preventive • *2 exams per calendar year* • *2 cleanings per calendar year* • *Complete X-rays every 36 months (non-orthodontic)* • *Supplemental bitewing X-rays two times per calendar year for children and once per year for adults* • *Fluoride treatments* • *Space maintainers for children under age 19* • *Sealants for children under age 19 (once in a lifetime, permanent molars only)*	*100% R&C** (Not subject to the annual deductible)*	*100% (Not subject to the annual deductible)*
Restorative • *Fillings – including amalgam (silver) and composite (white fillings)* • *Extractions* • *Root canals* • *Gum treatment* • *Night guard* • *Anesthesia*	*80% R&C***	*90%*
Prosthodontics • *Crowns, inlays, onlays* • *Implants* • *Installation and repair of bridgework* • *Installation and repair of dentures* • *Anesthesia*	*50% R&C***	*60%*
Orthodontics • *Braces to straighten teeth (employees, spouses/domestic partners, and dependent children through the end of month they turn age 26)* • *Lifetime Orthodontia Benefit (per covered individual): $2,000* **Annual Maximum (per participant, excluding orthodontics): $1,500**	*50% R&C***	*60%*

* If you use a network dentist, you will not be responsible for covered expenses in excess of your copayment amounts to the Plan maximums.

** R&C means reasonable and customary charges as determined by MetLife. These charges are considered to be reasonable in your area. The Plan does not cover charges over R&C. You may be billed by the provider for the amount over R&C.

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

ELIGIBILITY

Regular 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 dental benefits. In addition, you may also enroll your eligible dependents in these dental benefits. 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. Children under age 26 who are serving in the military are also eligible.
- Your **disabled children** age 26 or older, provided:
    - they became disabled before age 26;
    - they were enrolled in the Plan at the time they became disabled (or, in the case of a newly-hired employee with a child that is already disabled, the child was covered under the previous employer's medical or dental plan immediately prior to being covered under the Company's plan and is enrolled immediately upon the employee's employment);
    - they remain continuously enrolled in the plan following the disability; **and**
    - they qualify as your dependent for tax purposes (i.e., you can claim 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.
- Your **legal ward** up to age 26 for whom you are appointed legal guardian or legal custodian, provided that the individual qualifies as your dependent for tax purposes.*

Children of domestic partners cannot be covered under the plan, unless they are otherwise qualified as your dependents under the plan.
* It is your responsibility to ensure that your disabled child (age 26 or older) or legal ward qualifies as your dependent for tax purposes before enrolling or continuing to enroll him or her in the Plan. For a detailed explanation of the requirements for tax dependent status, see IRS Publication 17, Your Federal Income Tax, available at www.irs.gov.

Domestic partner

You 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. You may cover a domestic partner if both you and your 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 unlimited duration,
- Are not married to anyone else or involved in another domestic partner relationship,
- Share financial responsibilities through joint ownership or lease responsibilities of their residence, and/or have named each other as beneficiaries under life insurance policies or wills,
- Are not related by blood to such a degree that marriage would be prohibited under applicable state law (without regard to gender), and
- Are competent to make contracts (i.e., are not considered incompetent because of physical or mental disability).

Eligibility Verification

All employees must provide, upon request, written proof of eligibility of their dependents who are covered or who are requesting coverage under the Plan. Such written proof of eligibility must be submitted within the timeframe communicated by the Plan Administrator. Such proof of eligibility may include, but 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 for your dental benefits. These options will give you the opportunity to pick the coverage that best meets you and your family's needs. 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 employees of the Company, Berkshire Hathaway Energy Company, or any of its affiliates or subsidiaries, you cannot be covered as both an employee and a dependent under any dental programs sponsored by Berkshire Hathaway Energy Company or its affiliates or subsidiaries, including the Company. Also, your children cannot be covered by both parents. When enrolling for dental benefits, 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 dental coverage. If you waive coverage, you will not be able to enroll in Company-sponsored dental 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 the Dental Plan at that time.

- If you enroll within the first 31 days following your employment date, coverage will start as of your employment date. Any dental expenses you had before your employment date, however, will not be covered.
- If you do not enroll within the first 31 days following your employment date, you will not be able to enroll in the Dental Plan until the next annual Open Enrollment, unless you experience a Qualifying Life Event.

You will be able to enroll electronically in the Dental 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 will need to create a user ID and password.
- Via the Internet at http://digital.alight.com/dominionenergy
  - You'll need to enter your YBR user ID and password each time you access your account. The first time you go to YBR, click on Register as a New User and identify yourself by entering the last four digits of your Social Security number and your date of birth. You'll then be prompted to create a user ID and password.

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

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

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

CHANGING YOUR COVERAGE

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

An event 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 dental plan of another employer. Changes you make following a Qualifying Life Event must be on account of and consistent with the event.

Following is a listing of the types of changes that are permitted following the various Qualifying Life Events.* In addition to the changes described below, you may drop

coverage for your domestic partner at any time during the year, regardless of whether you experience a Qualifying Life Event.

Event	Enrollments Permitted	Cancellations Permitted
Dependent child events		
Birth, adoption, placement for adoption, appointment of legal guardianship, or death	• Add newly eligible child • Enroll self, spouse or domestic partner, newly eligible child and other child(ren)	• Drop deceased child
Satisfying or ceasing to satisfy eligibility requirements	• Add newly eligible child and other children	• Drop newly ineligible child
Qualified Medical Child Support Order	• Add child(ren) required by QMCSO • Enroll self, and child(ren) required by QMCSO	• Drop child(ren) if QMCSO requires spouse to provide coverage (and spouse does so) • 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	• Drop newly ineligible or deceased domestic partner
Domestic partner's change in employment or benefit eligibility status**	• Add domestic partner who lost coverage under their employer's plan	• Drop domestic partner who became covered under their employer's plan
Domestic partner's employer no longer contributes to their group dental coverage	• Add domestic partner	N/A
Employee events		
Employee's change in employment status**	• Enroll self, spouse or domestic partner, and children who became eligible under this Plan	• Drop self, spouse or domestic partner, and children who lost eligibility under this Plan
Other coverage events		
Open enrollment (non-calendar year) in other employer's plan	• Enroll self, spouse or domestic partner, and children whose coverage was dropped under other plan	• Drop self, spouse or domestic partner, and children whose coverage was added under other plan

Event	Enrollments Permitted	Cancellations Permitted
Loss of governmental or tribal group dental coverage	• Add spouse, domestic partner or children who lost other coverage • Enroll self, spouse, domestic partner, or children who lost other coverage	N/A
Relocation of spouse or domestic partner or children to or from another country	• Add spouse or domestic partner and children who moved to the U.S.	• Drop spouse or domestic partner and children who moved out of the U.S.
Spouse events		
Marriage	• Add spouse and children • Enroll self, spouse and children	• Drop self and children, if coverage is obtained under spouse's plan
Divorce, annulment or death of spouse	• Add children, if coverage is lost under spouse's plan • Enroll self and children, if coverage is lost under spouse's plan	• Drop spouse
Spouse's change in employment or benefit eligibility status **	• Add spouse and children who lost coverage under spouse's plan • Enroll self, spouse and children who lost coverage under spouse's plan	• Drop self, spouse and children who became covered under spouse's plan
Spouse's employer no longer contributes to their group dental coverage	• Add spouse and children who lost subsidy under spouse's plan • Enroll self, spouse and children who lost subsidy under spouse's plan	N/A

* These rules will be interpreted and administered in accordance with IRS rules and regulations.

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

IMPORTANT! When you experience a Qualifying Life Event, you must contact the Dominion Energy Benefit Center at 1-877-434-6996 **within 31 days of the event*** If your

event does not allow a benefit change, you will have to wait until the next annual Open Enrollment or another Qualifying Life Event to make a change to your benefits.

* The enrollment period to add dependent children is 60 days in the event of the birth, adoption or placement for adoption of your dependent child(ren). The enrollment period to enroll yourself and dependents is also 60 days in the event of 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 dental benefit elections. Changes you make at Open Enrollment are effective the following January 1.

Rehire/Reinstate

Solely to the extent required under IRS regulations, if you terminate employment 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 plan that changed, if another plan is available; or
- If you return to work after 31 days from the termination date, you are required to make new benefit elections.

YOUR COST OF COVERAGE

Contributions for employee, child and family coverage under the Dental Plan will be deducted from your pay on a pre-tax basis. Contributions for domestic partner coverage are in addition to the employee's level of coverage and are on an after-tax basis. Your contributions may vary from year to year and will depend on the category of coverage you select (employee only, etc.).

DENTAL BENEFITS

STANDARD DENTAL BENEFITS

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

NETWORK DENTAL BENEFITS
In addition to the Standard dental benefit, if you use a participating network dentist, the Network dental benefit provides 100% for preventive care, 90% for restorative, 60% for prosthodontic and 60% for orthodontia. Network dentists have agreed to accept a negotiated fee as full payment for covered services. This means you will not be responsible for any additional costs, provided that the services are covered by the Plan, except when:

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

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

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

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

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

DEDUCTIBLE, COINSURANCE AND MAXIMUM BENEFITS

DEDUCTIBLE
The Dental Plan requires that you pay an annual deductible of $25 per person or up to $75 per family before the Plan pays for most services. The deductible does not apply to preventive services or orthodontics.

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

The deductible can be met with standard and/or network covered expenses.

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

For more information, see "Schedule of Benefits" in this section.

MAXIMUM BENEFITS
The Dental Plan provides up to $1,500 standard or network benefits per person per calendar year and orthodontic benefits up to $2,000 per person per lifetime.

WHAT THE PLAN COVERS

The Plan provides a standard level of benefits based on a portion of the reasonable and customary charges for various local areas as determined by the insurance carrier. In some cases, MetLife may recommend a less costly course of treatment that it believes is a standard accepted service/material that will be just as effective as the treatment proposed by your dentist. If MetLife recommends such a course of treatment, the Plan will pay benefits only for the lower-cost course of treatment.

PREVENTIVE CARE
You and your covered dependents are encouraged to follow a course of preventive dental care.

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

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

PREVENTIVE CARE ITEMS COVERED

- Up to two exams in a calendar year.
- Two cleanings in a calendar year.
- Space maintainers for patients under age 19.
- Fluoride treatment.
- Sealants for children under age 19 (once in a lifetime, permanent molars only)
- Emergency treatment for pain. An emergency oral exam is not payable under the Plan as a separate procedure when performed in conjunction with emergency treatment to alleviate pain or when performed on the same day as treatment to correct the condition that caused the emergency.
- One full mouth x-ray during a 36-month period.
- Supplementary bitewing* x-rays every six (6) months for children and once per year for adults.
- Surgical removal of impacted teeth.**

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

**** Note:** For those individuals covered by the Medical Options, Anthem Blue Cross and Blue Shield is the primary administrator and MetLife is the secondary administrator. You should first file with Anthem. After that claim is processed, if any charges were not paid, the dental claim form should be completed showing the total fee charged, not the balance. Attach the Anthem Explanation of Benefits to the dental claim form and submit it to MetLife. No more than 100% of the R&C will be paid by this coordination of benefits.

RESTORATIVE CARE
Generally, restorative care is dental treatment to restore a tooth or the tissue around it. Fillings and simple extractions are common forms of restorative care. After the deductible

has been satisfied, restorative care is paid at 80% under the Standard benefit and 90% for network benefits.

RESTORATIVE CARE ITEMS COVERED

- Extractions: if the extraction is in connection with orthodontics, 50% of R&C under the Standard benefit, and 60% of Network benefits.
- Fillings of amalgam, silicate, acrylic, synthetic porcelain, or composite filling.
- Gold fillings (this will be paid only if the tooth cannot be restored by commonly used filling material).
- Oral surgery that is in connection with orthodontics is 50% of R&C under the Standard benefit and 60% under network benefits.
- Relining or rebasing of dentures (this benefit is paid only after six months following the installation of an initial or replacement denture but not more than once in any 36-consecutive-month period).
- Periodontal care (treatment of gums).
- Endodontics, including root canal therapy.
- Nightguard.
- Antibiotics (by injection only).
- Repair and recementing of crowns, inlays, onlays, bridgework, or dentures.
- Anesthetics when applied during restorative treatments.
- Temporomandibular Joint (TMJ) therapy and the TMJ appliance (adjustments to the appliance are not covered).
- Periodontal cleanings if related to periodontal surgery/active therapy (these cleanings are in addition to the two preventive cleanings per calendar year).

These definitions refer to the services mentioned in the preceding chart.

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

PROSTHODONTIC CARE

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

PROSTHODONTIC CARE ITEMS COVERED

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

These definitions refer to the services mentioned in the preceding chart.

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

The Plan does not cover all types of prosthodontic care. The following table lists some limitations.

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

ORTHODONTIC CARE

Orthodontic care covers the straightening of teeth with braces for covered employees, spouses and domestic partners, and dependent children up to age 26.

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

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

Orthodontic benefits from the Plan are limited to a $2,000 lifetime maximum per covered individual.

The following example illustrates the way benefits under the Plan are applied to orthodontic services.

$3,000	Estimated Charges for 24 months
x 20%	Allowed for Installation
$ 600	Installation Charge
	Standard benefit: The Plan will pay 50% R&C of the installation or $300*
	Network benefit: The Plan will pay 60% of the installation or $360*
$3,000	Estimated Charges
- 600	Installation Charges
$2,400	Balance of Charges
$2,400	Divided by 24 months = $100
	Standard Benefit: 50% or $50 paid monthly by MetLife
	Network benefit: 60% or $60 paid monthly by MetLife

***Note:** The $2,000 lifetime orthodontic maximum includes the Plan's payment for the installation charges.

WHAT TO DO IN AN EMERGENCY

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

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

PRE-TREATMENT ESTIMATE OF BENEFITS

The Dental Plan has a special provision, a "Pre-Treatment Estimate of Benefits," that can help you and your dentist know exactly how much the Plan will pay for certain treatments/services/materials.

If you or a covered dependent needs treatment that is likely to cost $100 or more, you should file for a pre-treatment estimate of benefits. Use the regular dental claim form and have your dentist write down a full description of the planned treatment. Send the form to MetLife.

MetLife will review the form and let you and your dentist know what benefits will be paid by the Plan.

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

If you do not file for a pre-treatment estimate of benefits, the Plan will still pay only the R&C for the standard accepted service/materials for the treatment. However, you will not

have the opportunity to find out about other methods of treatment that might have been available.

WHAT THE PLAN DOES NOT COVER

Although the Dental Plan covers many dental services, it will not pay benefits for *all* dental services. The following chart lists some of the items not covered under the Plan. This is not an all-inclusive list. If you have any questions about whether or not a treatment is covered, please contact MetLife at 1-800-942-0854 prior to receiving the service.

WHAT THE PLAN DOES NOT COVER
* Services or supplies covered by one of the Company's group medical plans, Workers' Compensation, Employee's Liability Law, or any government health plan. * Expenses for services rendered through a medical department, clinic, or similar facility provided or maintained by a patient's employer. * Treatment by someone other than a licensed dentist, except for cleaning or fluoride treatment by a dental hygienist. * Use of veneer crowns (thin crowns) or similar material to replace teeth, other than the ten upper and ten lower front teeth. * Services or supplies for cosmetic purposes such as capping healthy, natural teeth. * Any charges for treatment of conditions resulting from war or act of war. * Services ordered before your coverage began, or delivered or installed more than 90 days after your coverage ends. * Replacement of lost or stolen dentures or orthodontic retainers. * Replacement or repair of an appliance used to straighten teeth. * Penalties for failure to keep a scheduled dental appointment. * Services or supplies that are unnecessary according to accepted standards of dental practice *or* do not meet those standards *or* are experimental in nature.* * Duplicate dentures or appliances. * Oral hygiene and dietary instructions or an educational program, such as plaque control. (Sealants are covered up to age 19.) * Expenses for dentures or bridgework (including inlays and crowns to form abutments) replacing teeth you lost before you were covered under the Plan. * Braces for covered individuals age 26 or older. * Completion of insurance forms. * Analgesia – nitrous oxide. * Orthodontic services associated with correction of a cleft lip or cleft palate. * Services provided in a hospital, surgical center or urgent care facility.
***Note:** No benefits will be provided under this Plan for experimental treatments, procedures, and therapies. For these purposes, "experimental" means any medical procedure, treatment, or course of treatment that is (a) not proven in an objective manner to have benefit for the patient, (b) restricted to use at medical facilities engaged primarily in carrying out scientific studies, or (c) of questionable medical effectiveness. In determining whether a particular procedure is experimental, the Plan Administrator shall consider (among other things) commissioned studies, opinions, and references to or by the U.S. Food and Drug Administration, the U.S. Department of Health and Human Services, the Centers for Medicare and Medicaid Services (formerly HCFA), the National Institutes of Health, and any other association or federal program or agency that has the authority to approve medical testing or treatment.

COORDINATION OF BENEFITS

Coordination of benefits occurs when you have dental coverage through the Company and another employers' group plan.

Under the Dental Plan's coordination of benefits provision, benefits from this and any other plan will be coordinated so that benefits from both plans will not exceed 100% of expenses actually incurred. This provision will help to reduce claims against the Plan and reduce the cost of the Plan.

If you are covered by the Dental Plan as an employee, this Plan will be primary and will pay benefits first for your expenses. Any alternate dental coverage you have will be considered secondary and will pay benefits second.

If your spouse or domestic partner works 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. If he or she also is covered under the Dental Plan, it will be considered secondary for your spouse or domestic partner and will pay benefits second.

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

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

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

SPECIAL COVERAGE RULES

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

LEAVE OF ABSENCE

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

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

Contact the Dominion Energy Benefit Center at 1-877-434-6996 before your leave begins to make the necessary arrangements to pay your contributions while on leave, or immediately after your leave ends to make repayment arrangements for any contributions that accrued during your leave. Unless you make alternate payment arrangements upon your return to work, all accrued contributions will be deducted from your pay after your return to work.

WHEN COVERAGE ENDS
Coverage under the Plan will continue through the last day of the month in which any of the following occurs:

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

If you die, coverage will continue for your covered dependents at no cost to them until the end of the month following the month in which your death occurred.

Coverage for your spouse/domestic partner or dependents 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 (your children's coverage will continue);
* Your domestic partner no longer meets the eligibility requirements (see Eligibility section for details);
* Your dependents cease to qualify as dependents under the terms of the Plan:
    * Coverage for children who reach the age limit will cease on the last day of the month during which they attain age 26.

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 received 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.

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

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

* Your termination of employment.
* Your retirement.
* Your work hours are reduced to less than a regular, full-time status.
* Your disability.
* Your death.
* Your divorce
* Your child ceases to qualify for dependent coverage under the terms of the Plan.

For more information about COBRA coverage, please refer to the "Additional Information" SPD.

EXTENDED BENEFITS
There may be other circumstances in which coverage under the Plan could be extended.

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

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

FILING CLAIMS

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

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

Many dentists will file the form with the claims administrator for you. The administrator's name and address are on the form.

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

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

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

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

APPEAL AND REVIEW PROCESS

ENROLLMENT REVIEW

You can request a review of an enrollment/coverage decision made by the Plan Administrator. You must submit your request in writing to the Benefits Manager no later than 180 days after the date you received an enrollment/coverage decision. You can

submit any additional documents or written comments you feel are relevant to your request, and you can review and request copies of relevant documents from the Plan Administrator. The Benefits Manager will respond in writing within 60 days, unless special circumstances require an extension of up to 60 additional days to consider your request. You will be notified if any extension is needed.

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

DENTAL CLAIMS REVIEW

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

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

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

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

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

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

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criteria was relied upon in denying the claim on appeal, the final written

decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

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

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

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

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

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

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 Dental Plan.

PLAN DOCUMENTS

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