SUMMARY PLAN DESCRIPTION

FOR THE

HEALTH REIMBURSEMENT

ARRANGEMENT FOR EMPLOYEES REPRESENTED BY LOCAL 69 UNDER THE

BHE PIPELINE GROUP, LLC

RETIREE HEALTH AND WELFARE PLAN

January 1, 2021

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INTRODUCTION

BHE Pipeline Group, LLC has established a Health Reimbursement Arrangement (the "HRA") for the benefit of its retirees and the retirees of its participating affiliates, effective November 1, 2020. The HRA is part of the BHE Pipeline Group, LLC Retiree Health and Welfare Plan (the "Plan"). The purpose of the HRA is to reimburse eligible retirees for certain insurance premiums and medical expenses which are not otherwise reimbursed by any other plan or program. The HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45.

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

Note that capitalized terms used in this summary plan description ("SPD") are defined the first time they are used or are defined in Appendix A: General Plan Information at the end of this booklet. Please note that "you," "your" and "my" when used in this SPD refer to you, the retiree.

PART I
GENERAL INFORMATION ABOUT THE HRA

Q-1. What is the purpose of the HRA?

The purpose of the HRA is to reimburse Participants for Eligible Medical Expenses (as defined in Q-12) which are not otherwise reimbursed by any other plan or program. Reimbursements for Eligible Medical Expenses paid by the HRA generally are excludable from the Participant's taxable income. See Q-2 through Q-6 for information about who may qualify as a "Participant."

Q-2. Which retirees can participate in the HRA?

Full-time employees of Eastern Gas Transmission and Storage, Inc. who are represented by The United Gas Workers' Union Local 69, UWUA, AFL-CIO (the "Union") and meet the requirements described below in this Q-2 are eligible to participate in the HRA.

If you were eligible to receive retiree medical benefits prior to November 1, 2020, upon your retirement, you are eligible to receive the retiree medical benefits that you would have received as of October 31, 2020 through Dominion Energy Company. You become an Eligible Retiree for purposes of the HRA to the extent that you would have received additional retiree medical benefits as a result of your ongoing service with the Company on or after November 1, 2020.

Active full-time Union employees as of June 30, 2017 – Once you have retired and reached Medicare eligibility at age 65, you must satisfy the following criteria to be an Eligible Retiree:

- You must be at least age 55 (58 effective April 1, 2023) when you retire from active employment with Dominion;
- You must have at least 10 years of pension service when you retire from active employment with Dominion;

Please note that if you were hired after March 23, 2017, you are ineligible for retiree medical benefits.

Independent Contractors – If you were classified by the Company as an independent contractor, you are not eligible to participate in the HRA, unless you are also otherwise classified by the Company as

a former employee who satisfies the Eligible Retiree requirements above. Individuals classified as independent contractors remain ineligible for the HRA even if they are later determined by a court or governmental agency to be or to have been a former common law employee of the Company rather than an independent contractor.

Q-3. Can my spouse participate in the HRA?

Your Eligible Spouse may participate in the HRA upon reaching age 65. Your spouse is your "Eligible Spouse" if:

- You are an Eligible Retiree;
- You were legally married to your spouse when you retired from Dominion, and you have been continuously married since that time; and

An Eligible Spouse may continue to participate in the HRA after the death of an Eligible Retiree, as further described in Q-19.

Q-4. Can my dependents participate in the HRA?

Your dependents (other than your Eligible Spouse or Eligible Disabled Child) will not receive separate Stipend Credits under the HRA and are therefore not "Participants" in the HRA. However, you are entitled to be reimbursed from your HRA for any Eligible Medical Expenses you incur on behalf of your Eligible Dependents.

Your "Eligible Dependents" generally include your legal spouse and any other individual who is your dependent for federal income tax purposes at the time of your retirement. Dependent children include children under age 26 who are your natural children, legally adopted children, children placed with you for legal adoption, foster children, and stepchildren. You may be required to provide proof of dependent status upon request by the HRA Administrator (or its designee). Failure to provide such proof may result in a delay or denial in benefits provided under the HRA.

In addition, the HRA will allow reimbursement of Eligible Medical Expenses for a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order ("QMCSO") to the extent the QMCSO does not require coverage not otherwise offered under this HRA. The HRA Administrator will make a determination as to whether the order is a QMCSO in accordance with the HRA's QMCSO procedures. The HRA Administrator will notify both you and the affected child once a determination has been made. You may request a copy of the HRA's QMCSO procedures, free of charge, by contacting the HRA Administrator at the address listed in Appendix A: General Plan Information.

Q-5. How can my children receive coverage during my retirement?

Dependent children under age 19 (or, if a full-time student, under age 25) may be eligible for coverage under the BHE Pipeline Group, LLC Retiree Health and Welfare Plan. Please refer to the separate Summary Plan Description that applies to pre-65 retiree medical coverage for more details about eligibility and benefits under that program.

Although these children are under age 65 and would not be HRA Participants, you may use your HRA to reimburse certain eligible out-of-pocket expenses that they incur that are not otherwise covered by pre-65 retiree medical coverage, as described in Q-4.

Q-6. What if I have a permanently disabled child?

If your child is permanently disabled and under age 65, your child may qualify for coverage under the BHE Pipeline Group, LLC Retiree Health and Welfare Plan for participants who are under age 65. Please refer to the separate Summary Plan Description that applies to pre-65 retiree medical coverage for more details about eligibility and benefits under that program.

Your disabled child who has reached age 65 and been continuously covered as your dependent under the BHE Pipeline Group, LLC Retiree Health and Welfare Plan since your retirement qualifies as an "Eligible Disabled Child" who may become a Participant in the HRA. As an HRA Participant, your Eligible Disabled Child will receive annual Stipend Credits equal to the applicable spousal HRA Stipend Credit.

Please keep in mind that if you drop pre-65 coverage or HRA participation for the child at any point, neither the pre-65 coverage nor HRA participation can be reinstated in a future year.

Q-7. When do I actually become a Participant in the HRA?

Participation to make Eligible Retiree whole for service with the Company.

An Eligible Retiree, Eligible Spouse, or Eligible Disabled Child becomes a Participant in the HRA on the date that he or she has satisfied all of the following requirements:

- He or she was eligible for retiree medical benefits through Dominion Energy Company prior to November 1, 2020;
- He or she would have been entitled to greater retiree medical benefits as a result of the Eligible Retiree's service with the Company from November 1, 2020 to the Eligible Retiree's retirement date; and
- He or she has completed any enrollment forms or procedures required by the HRA Administrator.

Participation based on Medicare eligibility.

An Eligible Retiree, Eligible Spouse, or Eligible Disabled Child actually becomes a Participant in the HRA on the date that he or she has satisfied all of the following requirements:

- He or she has enrolled in Medicare upon reaching age 65;
- He or she has obtained an individual medical insurance policy through ViaBenefits (or any of its affiliates); and
- He or she has completed any enrollment forms or procedures required by the HRA Administrator.

Q-8. What if I am already age 65 (or my spouse is already age 65) when I retire from the Company?

If you or your spouse is already age 65 when you retire from the Company and you are an Eligible Retiree, you or your spouse (as applicable) must enroll in a medical plan through ViaBenefits to be effective no later than the first day of the month following your retirement date. Your active employee medical, dental, and vision benefits (if any) will be extended for an additional month to ensure that you have sufficient time to enroll in coverage through ViaBenefits.

Example: You are at least age 65 as of August 31, and you are enrolled in The Company's medical

benefits for active employees represented by The United Gas Workers' Union Local 69, UWUA, AFL-CIO. Your last day of employment is August 31, and your retirement is effective September 1. Your active employee coverage will continue through the end of September, and you should enroll in a medical plan through ViaBenefits, effective October 1. If neither you nor your spouse was at least age 65 as of August 31, your active employee coverage would have continued only through the end of August, and you would be required to elect the Company's pre-65 coverage effective September 1.

Q-9. How does the HRA work?

On the first day of each Plan Year, the Company will credit Stipend Credits to your HRA. You and your Eligible Spouse will each receive separate annual Stipend Credit amounts. The law does not permit Participants to make any contributions to their HRAs.

In your first year of retirement, your Stipend Credit will be prorated as described in Q-10 below, unless your retirement date is effective on January 1.

Your HRA will be reduced from time to time by the amount of any Eligible Medical Expenses for which the Participant is reimbursed under the HRA. At any time, the Participant may receive reimbursement for Eligible Medical Expenses up to the amount in his or her HRA. Unused Stipend Credits may be carried over for use in a future year.

An HRA is merely a bookkeeping account on the Company's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the HRA are paid entirely from the Company.

Q-10. What is the amount of my annual Stipend Credit?

Participation to make Eligible Retiree whole for service with the Company.

The Stipend Credit provided by the Company will equal the difference between (i) the [value of the] retiree medical company subsidy you received through Dominion Energy Company and (ii) the [value of the] retiree medical company subsidy you would have received as a result of the Eligible Retiree's ongoing service with the Company from (x) November 1, 2020 to (y) his or her retirement date. The value of the retiree medical benefits will be calculated based on the Eligible Retiree's years of service with Dominion Energy Company and the Company, age, hire date, and retirement date. The Stipend Amount will be calculated as an annual amount, which will be prorated for the number of months in which you participate in the HRA.

Participation based on Medicare eligibility

The amount of the 2021 annual Stipend Credits are shown on Appendix B for Eligible Retirees and Eligible Spouses (an Eligible Disabled Child receives an annual Stipend Credit equal to the applicable Eligible Spouse Stipend Credit as described in Q-6 above). Additionally, you will receive the Supplemental Annual Stipend Credit as described below and in Appendix B. These are annual amounts, which will be prorated for the number of months in which you participate in the HRA. For example, if you begin participating in the HRA on July 1, 2021, you will receive 6/12 of the annual Stipend Credit amount for 2021, which will be credited to your HRA on July 1, 2021.

The Supplemental Annual Stipend Credit is credited to the HRA of either the Eligible Retiree or his or her Eligible Spouse. If the Eligible Retiree has no Eligible Spouse or reaches age 65 before his or her Eligible Spouse, the Supplemental Annual Stipend Credit is credited to the retiree's HRA. If the Eligible Spouse reaches age 65 before the Eligible Retiree, or if the Eligible Retiree has died when the Eligible

Spouse begins participating in the HRA, it is credited to the Eligible Spouse's HRA. *Keep in mind that HRAs can be used to pay for Eligible Medical Expenses incurred by any Eligible Dependent, including a spouse. Therefore, amounts credited to the Eligible Retiree's HRA can be used by the Eligible Spouse, and amounts credited to the Eligible Spouse's HRA can be used by the Eligible Retiree.*

Q-11. Will my annual Stipend Credit keep up with rising medical costs?

The Company will adjust the Retiree and Spousal Stipend Credit amounts each year to keep up with medical care inflation, as reflected in the medical consumer price index published by the Bureau of Labor Statistics for the 12-month period ending each June. The Supplemental Annual Stipend Credit is not required to be indexed.

Q-12. What is an "Eligible Medical Expense"?

An Eligible Medical Expense is an expense incurred by you or any Eligible Dependent for medical care, as that term is defined in Internal Revenue Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of Eligible Medical Expenses include:

- Premiums for medical, prescription drug, dental, vision or long-term care insurance;
- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids; and
- Wheelchairs.

Some examples of common items that are <u>not</u> Eligible Medical Expenses include:

- Out-of-pocket expenses for prescription drugs and insulin (remember that your insurance premiums for prescription drug coverage **are** Eligible Medical Expenses);
- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or trauma, or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items are and are not Eligible Medical Expenses, consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Aren't Includible." (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement account.) If you need more information regarding whether an expense is an Eligible Medical Expense under the HRA, contact the HRA Administrator as provided in Appendix A: General Plan Information.

Only Eligible Medical Expenses incurred while a Participant in the HRA may be reimbursed from your HRA. Eligible Medical Expenses are "incurred" when the medical care is provided.

Thus, an expense that has been paid but not incurred (e.g., pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an HRA:

- expenses incurred for qualified long -term care services;
- expenses incurred *prior to the date* that you became a Participant in the HRA;
- expenses incurred *after the date* that you cease to be a Participant in the HRA;
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; and
- any other expenses specifically identified as excluded.

Q-13. How do I obtain prescription drug coverage?

ViaBenefits will help you select prescription drug coverage at the same time that you are choosing your supplemental medical coverage. Depending on the type of medical coverage that you select, your prescription drug coverage may be part of your medical plan or it may be a separate plan. Your HRA can be used to reimburse premiums for prescription drug coverage purchased through ViaBenefits.

Q-14. What is "Catastrophic Coverage" for out-of-pocket prescription drug costs?

You may have out-of-pocket prescription drug expenses (e.g., coinsurance or co-pays) that are not covered by your prescription drug insurance plan. As part of the HRA program, the Company offers protection in the event that your eligible out-of-pocket prescription drug costs for the year exceed the "catastrophic coverage" level, as defined annually by Medicare.

Once you have reached the catastrophic coverage level for the year, all eligible out-of-pocket prescription drug expenses that you incur through the end of the Plan Year will be reimbursed without limit. To receive reimbursement, you must submit a claim. To obtain a catastrophic coverage claim form, contact customer service at ViaBenefits.

Q-15. What if I am prescribed a drug that is not covered by my ViaBenefits plan?

When you first enroll with ViaBenefits, they will help you find a prescription drug plan that covers the prescription drugs you are currently prescribed. In the unlikely event that you cannot find a plan that covers the prescription drug you need, or a suitable alternative, your collective bargaining agreement includes a special provision that may provide you with reimbursement from the Company for the cost of the non-covered drug. This can apply to prescriptions you had at the time of your ViaBenefits enrollment, or to prescriptions you obtain later, if they are not covered by an available ViaBenefits plan and they would have been covered by the Company's medical plan you were enrolled in prior to enrolling in a plan through ViaBenefits. Your collective bargaining agreement contains the details and limits of this special provision, including several steps you must follow before filing a claim for reimbursement. If you have exhausted all the required steps, you may file a written claim with the MidAmerican Benefits Director, c/o BHE Pipeline Group, LLC 666 Grand Avenue, Des Moines, IA 50309, to request reimbursement under this special provision. Your claim will be resolved in accordance with rules summarized below under "What happens if my claim for benefits is denied?", except that your claim will be filed directly with MidAmerican's Benefits Director. Any reimbursement under this

special provision is in addition to the Stipend Credits allocated to your HRA.

Q-16. When does HRA participation end?

You will cease being a Participant in the HRA on the earlier of:

- the date you cease to be an Eligible Retiree for any reason;
- the date you are rehired by the Company as an active employee;
- the date you cease to be eligible for Medicare;
- the date you are no longer enrolled in a ViaBenefits plan and no longer have an account balance; or
- your date of death.

Participation for an Eligible Spouse ceases on the earlier of:

- the date the spouse is no longer an Eligible Spouse for any reason;
- the date the spouse ceases to be eligible for Medicare;
- the date the spouse and the Eligible Retiree divorce;
- the date the spouse is no longer enrolled in a ViaBenefits plan and no longer has an account balance;
- the date the retiree is rehired by the Company as an active employee; or
- the date of the spouse's death.

Participation for an Eligible Disabled Child ceases on the earlier of:

- the date the child is no longer an Eligible Disabled Child for any reason;
- the date the child ceases to be eligible for Medicare;
- the date the child is no longer enrolled in a ViaBenefits plan and no longer has an account balance;
- the date the retiree is rehired by the Company as an active employee; or
- the date of the child's death.

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date your eligibility ceases. You have 180 days after your eligibility ceases, however, to request reimbursement of Eligible Medical Expenses you incurred before your eligibility ceased.

In addition, your Eligible Spouse may be eligible to continue coverage under the HRA beyond the date that his or her coverage would otherwise end if coverage is lost for certain reasons. These continuation of coverage rights and responsibilities are described in Q-26 below.

If you are no longer enrolled in a ViaBenefits plan, you may come back in a later year by enrolling in a ViaBenefits plan for that year. But you will not receive any HRA Stipend Credits for a year in which you are not enrolled in a ViaBenefits plan.

Q-17. What happens if I do not use all of the Stipend Credits allocated to my HRA during the Plan Year?

Unused amounts will be carried over to subsequent Plan Years.

Q-18. How do I receive reimbursement under the HRA?

You must complete a reimbursement form and mail or fax it to the Claims Submission Agent as provided in Appendix A: General Plan Information, along with a copy of your insurance premium bill, an "explanation of benefits" or "EOB," or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. You can obtain a reimbursement form from the HRA Administrator identified in Appendix A: General Plan Information. Your claim is deemed filed when it is received by the Claims Submission Agent. (Do not mail your form to the HRA Administrator as this may result in a delay in processing.)

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

The HRA Administrator may be able to set up recurring automatic reimbursement for your plan premiums.

Q-19. What happens if my claim for benefits is denied?

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Submission Agent receives your claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the HRA, the Claims Submission Agent will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the HRA provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the HRA's appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the HRA is denied in whole or in part and you do not agree with the decision of the Claims Submission Agent, you may file a written appeal. You should file your appeal with the HRA Administrator at the address provided in the Plan Information Appendix no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the HRA Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Submission Agent.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

Q-20. What happens if I die?

If the Eligible Retiree dies with no Eligible Spouse who is a Participant in the Plan, his or her HRA is

immediately forfeited upon death, but the deceased Eligible Retiree's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree and his or her Eligible Dependents before his or her death. Claims must be submitted within 180 days of his or her death.

If the Eligible Retiree dies with an Eligible Spouse or Eligible Disabled Child who is an HRA Participant as of the date of death, the balance remaining in the HRA may continue to be used by the Eligible Spouse or Eligible Disabled Child (as applicable) after the retiree's death. Annual spousal or disabled child Stipend Credits will continue to be credited so long as the Eligible Spouse or Eligible Disabled Child continues to be a Participant, but no further retiree Stipend Credits will be provided after the retiree has died.

However, if the Eligible Retiree was receiving the Supplemental Annual Stipend Credit prior to death and is survived by his or her Eligible Spouse, the Supplemental Annual Stipend Credit will be credited to the Eligible Spouse's HRA in future years during which the Eligible Spouse participates in the HRA. Similarly, if the Eligible Spouse was receiving the Supplemental Annual Stipend Credit prior to death and is survived by his or her Eligible Retiree spouse, the Supplemental Annual Stipend Credit will be credited to the Eligible Retiree's HRA in future years during which the Eligible Retiree participates in the HRA.

If the Eligible Retiree dies with an Eligible Spouse or disabled child who is not yet age 65, the Eligible Spouse or disabled child may begin receiving annual spousal or disabled child Stipend Credits upon reaching age 65 and becoming an HRA Participant. Before reaching age 65, the Eligible Spouse or disabled child would continue to be covered under Dominion's retiree medical benefits for participants under age 65.

Q-21. Are my benefits taxable?

The HRA is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the HRA are not taxable to you.

Q-22. What happens if I receive an overpayment under the HRA or a reimbursement is made in error from my HRA?

If it is later determined that you or your Eligible Dependent received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA for an expense that is later paid by another medical plan), you or your Eligible Dependent will be required to refund the overpayment or erroneous reimbursement to the Company.

If you do not refund the overpayment or erroneous payment, the Company reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Company. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

Q-23. How long will the HRA remain in effect?

Refer to the *Changing or Terminating the Plans* section of the Additional Information SPD.

Q-24. How does the HRA interact with other medical plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been

satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to this HRA for reimbursement.

Q-25. What if I reside outside of the United States?

If you reside outside of the United States, contact the Plan Administrator for more details. Eligible Retirees and their Eligible Spouses who reside outside of the United States may be able to participate in the HRA by obtaining other health coverage in lieu of an individual health insurance policy through ViaBenefits.

Q-26. What is "continuation coverage" and how does it work?

Under a federal law called "COBRA," an Eligible Spouse and an Eligible Disabled Child who is covered under the HRA (a "qualified beneficiary") may elect to continue coverage under the HRA for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Participant, the Participant's death or a dependent child ceasing to be an Eligible Dependent. These are called "qualifying events."

Note that the qualified beneficiaries are required to notify the HRA Administrator in writing of a divorce or legal separation or a dependent child losing dependent status within 60 days of the event or they will lose the right to continue coverage under the HRA.

If a qualified beneficiary elects to continue coverage, he or she is entitled to the level of coverage under the HRA in effect immediately preceding the qualifying event. He or she may also be entitled to an increase in his or her HRA equal to the amounts credited to the HRAs of similarly situated Participants (subject to any restrictions applicable to similarly situated Participants) so long as he or she continues to pay the applicable premium.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary's HRA is exhausted;
- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- Dominion ceases to provide any group health plan.

Q-27. Who do I contact if I have questions about the HRA?

If you have any questions about the HRA, you should contact the HRA Administrator or the Plan Administrator. Contact information for the HRA Administrator and the Plan Administrator is provided in Appendix A: General Plan Information.

PART II
ERISA RIGHTS

This HRA is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that you, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Plan Coverage

Continue Plan coverage for your eligible spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, your spouse or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S.

Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART III
LEGAL NOTICES

Mothers' and Newborns' Health Protection Act

The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Women's Health and Cancer Rights Act

To the extent the Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses, and coverage of physical complications at all stages of the mastectomy, including lymphedemas.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction. This notice applies to you if you are covered as an employee, former employee or dependent under a group health plan sponsored by Dominion Resources, Inc. or one of its affiliates (collectively referred to in this notice as the "Company"). The group health plans covered by this notice include the Company's medical, dental, and vision care plans and health care flexible spending accounts (collectively, the "Plan").

This notice describes the legal obligations of the Plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act").

Protected Health Information. The HIPAA privacy rules regulate the use and disclosure by the Plan of "protected health information" (commonly referred to as "PHI"). PHI is any "individually identifiable health information" maintained or transmitted by the Plan (in any form or medium). Individually identifiable health information is health information that identifies you or creates a reasonable basis to believe that it could be used

to identify you, including information relating to your health condition or receipt of health care. Health information that is merely in summary form and that does not identify you as its subject is not PHI and may be used or disclosed by the Plan without restriction under the HIPAA privacy rules. For example, the Company may use aggregated data regarding claims paid for all Plan participants to help project benefit costs for the next year. With respect to PHI, however, the HIPAA privacy rules prevent the Plan from using your PHI or disclosing it to the Company or anyone else except as permitted by the HIPAA privacy rules, as authorized by you, or as required by law.

How the Plan May Use and Disclose Your Protected Health Information. Under HIPAA, the Plan may use or disclose your PHI under certain circumstances without your permission, as described below in the following categories:

For Treatment, Payment, and Health Care Operations. The HIPAA privacy rules permit the Plan and its business associates to use or disclose your PHI without your authorization for purposes of treatment, payment, and health care operations. This may be necessary in order to provide you with health care. Business associates include the Plan's third party claim administrators, as well as brokers, service providers, lawyers, accountants, consultants, and other appropriate persons who help to ensure that the Plan is run properly and that you receive any benefits to which you are entitled. PHI may also be shared among the Company's various group health plans that make up the Plan for purposes of treatment, payment, or health care operations. The terms "treatment," "payment," and "health care operations" are explained below:

- "Treatment" means generally the provision, coordination, or management of health care and related services by one or more health care providers. For example, the Plan may disclose your PHI to your doctor and his staff, the Plan's third party administrators and their staffs, and other appropriate persons to help provide you with proper medical treatment.

- "Payment" means any action undertaken by the Plan to obtain premiums, to determine responsibility for providing coverage, or to obtain or provide reimbursement for the health care services you receive. This includes, but is not limited to, eligibility and coverage determinations, billing, claims management and processing, plan reimbursement, reviews for medical necessity, utilization review, and pre-authorization for treatment. For example, the Plan may disclose to your doctors and their staff, the Plan's third party administrators and their staffs, and other appropriate persons information concerning a particular medical procedure to determine whether the procedure is covered by the Plan.

- "Health care operations" means all the activities involved in the administration of the Plan. This includes, but is not limited to, assessment and improvement, evaluating providers, underwriting and other activities relating to obtaining or amending insurance contracts, disease management, cost management, and other general administrative activities. For example, the Plan may use PHI about you to evaluate the care you are receiving from your providers, or to project benefit costs and determine premiums. However, the Plan will not use your genetic information for underwriting purposes.

For Treatment Alternatives or Health-Related Benefits and Services. The Plan may use and disclose your PHI to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. The Plan may contract with individuals or entities known as business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or services, business associates may receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with the Plan to implement appropriate safeguards regarding your PHI. For example, the Plan may disclose your PHI to a business associate to process your claims for Plan benefits or to provide support services, such as utilization management or pharmacy benefits management.

As Required by Law. The Plan will disclose your PHI when required to do so by federal, state, or local law. For example, the Plan may disclose your PHI when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your PHI in a proceeding regarding the licensure of a physician.

To the Company as Plan Sponsor. For purposes of administering the Plan, the Plan may disclose to certain Company employees PHI. However, these employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without specific authorization.

For Other Special Situations. In addition, the HIPAA privacy rules permit the Plan to use or disclose your PHI: (i) to facilitate organ and tissue donation and transplantation, if you are an organ donor; (ii) to the military, as required by military command authorities; (iii) for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and other similar programs that provide benefits for work-related injuries or illness; (iv) for public health activities (e.g., to prevent or control disease, injury, or disability or report births, deaths, and child abuse or neglect); (v) for health oversight activities necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws; (vi) for lawsuits and disputes in response to a subpoena, discovery request, or other court or administrative order, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested; (vii) for law enforcement purposes; (viii) to a coroner, medical examiner, or funeral director to carry out their duties; (ix) for national security and intelligence activities authorized by law; (x) to correctional institutions and for other law enforcement custodial situations in relation to an inmate; (xi) for research, subject to detailed requirements.

Uses and Disclosures Requiring That You Receive an Opportunity to Agree or Object. Certain circumstances might arise where the Plan needs to disclose your PHI to family members or another person designated by you in order to ensure that you are receiving appropriate care and to notify certain persons of your medical condition. The Plan will make such disclosures only if you have agreed (or have not objected) to the disclosure. Specifically, the Plan may disclose your PHI to your family member or another person designated by you, but only to the extent the information is directly relevant to such individual's involvement with your care or payment for care. The Plan may also disclose your PHI to notify or assist in notifying your family member or other person responsible for your care of details regarding your location or your general condition. In such cases, you will be given an opportunity to agree or object to the disclosure, and the disclosure will be made only if you either affirmatively agree or you do not object to the disclosure when given the opportunity. If you are incapacitated, the Plan may disclose your PHI to such individuals without providing you with an opportunity to agree or object, if the Plan determines that to do so is in your best interests under the circumstances.

Uses and Disclosures Requiring Your Written Authorization. Where use or disclosure is not otherwise permitted under the HIPAA privacy rules, the Plan is required to obtain your written authorization before using or disclosing your PHI. For instance, the Plan is required to ask for your written authorization before using or disclosing notes about you obtained from your psychotherapist. If you choose to sign a written authorization to disclose information, you can later revoke that authorization in writing at any time to stop future uses and disclosures, except to the extent the Plan has acted in reliance upon your authorization. The revocation will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your revocation.

Reservation of the Plan's and Company's Rights. Generally, it is the Plan's policy to avoid the use and disclosure of your PHI whenever possible. Therefore, the Plan will not normally use or disclose your PHI, except when necessary for treatment, payment, or health care operations or to comply with the HIPAA privacy rules or other applicable law. However, the Plan reserves the right to use or disclose your PHI in any manner permitted by the HIPAA privacy rules. The Company is also committed to the protection of your PHI and generally seeks to avoid the use and disclosure of your PHI whenever possible. Please remember that health information maintained by the Company as part of your employment records or through a benefit plan of the Company that is not part of the Plan, such as a short- or long-term disability plan, is not subject to the HIPAA privacy rules and may be used or disclosed in accordance with the Company's standard policies (subject to applicable law).

Your Rights. You have the following rights with respect to your PHI:

Right to Inspect and Copy. You have the right to review and receive copies of your PHI maintained by the Plan in a designated record set or used by the Plan to make decisions about your coverage or benefits. The term "designated record set" means the enrollment, payment, claims adjudication, and case or medical management records maintained by the Plan. If you request copies of this information, you will be charged $0.25 for each page. If the information you request is maintained electronically, and you request an electronic copy, the Plan will provide you a copy in the electronic form and format you request, if the information can be readily produced in that form and format. If the information cannot be readily produced in that form and format, the Plan will work with you to come to an agreement on the form and format. If we cannot agree on an electronic form and format, the Plan will provide you with a paper copy. Your request should be made in writing to the Director, HR Total Rewards and Labor Relations at the address listed below, and must clearly describe the specific information you are requesting. The Plan will comply with the request within 30 days of your request (60 days if the information is maintained offsite), subject to a possible 30-day extension. Your request may be denied in certain, very limited circumstances. If your request is denied, you will receive a written explanation of the reasons for the denial. If you are denied access to the information, you may request that the denial be reviewed by submitting a written request to Director, HR Total Rewards and Labor Relations at the address listed below. Please remember that the Plan is only responsible for providing you with information contained in its records. Hospital records and other records not maintained by the Plan must be procured directly from the individual or institution that maintains those records.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include: (i) disclosures for purposes of treatment, payment, or health care operations; (ii) disclosures made to you; (iii) disclosures you have authorized; (iv) disclosures incidental to a disclosure that is otherwise permitted under this privacy policy; (v) disclosures required for law enforcement or national security purposes; or (iv) disclosures made to friends or family in your presence because of an emergency. You may request one such accounting at no charge every 12 months. For any additional requests, you will be charged $0.25 per page. Your request must be submitted in writing to Director, Benefits at the address listed below, and must state the time period you want this list or accounting of disclosures to cover, which may not be longer than six years before the date of this request.

Right to Amend. If you believe that information in your record is incorrect or incomplete, you have the right to request that the Plan correct existing information or add missing information. You have the right to request an amendment for as long as the information is kept by the Plan. Your request must be made in writing to Director, Benefits at the address listed below and must state reason(s) supporting your request for a correction or addition. The Plan has 60 days to respond to your request, subject to a possible 30-day extension. The Plan may deny your request if you ask the Plan to amend information that: (i) is not part of the medical information kept by or for the Plan; (ii) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (iii) is not part of the information that you would be permitted to inspect or copy; or (iv) is already accurate and complete. If your request is denied, you will receive a written explanation of the reasons for the denial. If the Plan denies your request, you have the right to file a statement of disagreement with

the Plan directed to the Director, Benefits at the address listed below and any future disclosures of the disputed information will include your statement.

Right to Request Restrictions. You have the right under HIPAA to request restrictions on the Plan's use or disclosure of your PHI for treatment, payment, and health care operations. You may also request restrictions on disclosures to your family members or other individuals who are involved in your care or payment for your care, such as a friend or family member. The Plan will consider your request, but is not required to agree to such restrictions. Any restriction agreed to by the Plan will not apply if the use or disclosure is necessary to provide you with emergency treatment. Further, the Plan generally will not agree to restrictions on disclosures related to the Plan's treatment, payment and health care operations. If you wish to request a restriction on disclosures of your PHI, you must send your request in writing to Director, Benefits at the address listed below. In your written request, you must tell the Plan: (i) what information you want to limit; (ii) whether you want to limit the Plan's use, disclosure, or both; and (iii) to whom you want the limits to apply (ex: disclosures to your spouse). If the Plan accepts your request, you will receive written notification from Director, Benefits that your request has been accepted.

Right to Request Confidential Communications. The Plan will also accommodate reasonable requests for you to receive communications of your PHI at alternate locations or by alternate methods. For example, you may ask that the Plan only contact you at work or by mail. To request confidential communications, you must make the request in writing to Director, Benefits at the address listed below. Your request must specify how or where you wish to be contacted. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests.

Right to Request a Paper Copy of This Notice. You may request a paper copy of this notice at any time by contacting the Dominion Energy HelpLine 1-877-947-4636, or at the address listed below. You may also obtain a copy of this notice online via the HR DomNet homepage under Policies & Programs.

Right to Be Notified of a Breach. You have the right to be notified in the event that the Plan (or a business associate of the Plan) discovers a breach of your unsecured PHI.

Personal Representatives. You may exercise your rights through a personal representative, provided that such individual produces evidence of his or her authority to act on your behalf. The Plan will only accept the following as evidence of such authority: (1) a power of attorney for health care purposes notarized by a notary public; (2) a court order appointing the individual as your conservator or guardian; or (3) proof that such individual is your parent (if you are a minor). Your personal representative will be treated as you would with respect to access to your PHI and your other rights under the HIPAA privacy rules. However, the Plan retains the discretion to deny your personal representative access to your PHI if the Plan finds evidence that such denial is necessary to protect you from abuse or neglect.

The Plan's Legal Duties. The HIPAA privacy rules require the Plan to maintain the privacy of your PHI, to provide this notice about its information practices, and to follow the practices described in this notice. The Plan may change its privacy policies at any time, and changes may apply to all PHI held by the Plan at the time of the change. If the Plan makes a significant change in policy, a revised Notice of Privacy Practices will be distributed to all current Plan participants within 60 days of the effective date of the change.

This notice and the privacy policies of the Plan and the Company do not create any legal rights, contractual or otherwise, under state or federal law, but simply give you notice of the Plan's obligations and your rights under the HIPAA privacy rules.

Complaints. If you are concerned that the Plan has violated your rights under the HIPAA privacy rules, you may contact the Benefits, Director. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC

20201. Neither the Plan nor the Company will retaliate against you in any way for exercising your right to file a complaint.

You may contact the Director, Benefits at the following address and phone number for more information on the Plan's privacy practices:

MidAmerican Energy Company
Benefits Director
666 Grand Avenue
Des Moines, IA 50309
515-242-4300

APPENDIX A: GENERAL PLAN INFORMATION

Name of Plan:	BHE Pipeline Group, LLC Retiree Health and Welfare Plan
HRA Effective Date:	November 1, 2020
Name, address, and telephone number of the Plan Sponsor:	BHE Pipeline Group, LLC666 Grand AvenueDes Moines, IA 50309515-242-4300
Name, address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the discretion to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	MidAmerican Energy Company Employee Benefits Plans Administrative Committee 666 Grand Avenue Des Moines, IA 50309 515-242-4300
Agent for Service of Legal Process on the Plan Administrator or Plan Sponsor:	MidAmerican Energy Company Employee Benefits Plans Administrative Committee Secretary c/o BHE Pipeline Group, LLC PO Box 657 Des Moines, IA 50306-0657
Sponsor's federal tax identification number:	BHE Pipeline Group, LLC's Employer Identification Number is 94-2213782
Plan Number:	502
Plan Year:	January 1 through December 31
HRA Administrator:	Via Benefits 10975 South Sterling View Drive Suite A-1 South Jordan, UT 84905 Telephone: (855) 238-0483 my.viabenefits.com

Claims Submission Agent: All reimbursement forms, and supporting documentation, must be provided to the Claims Submission Agent. Forms should not be mailed to the HRA Administrator.	PayFlex Systems USA, Inc. Willis Towers Watson Via Benefits P.O. Box 3039 Omaha, NE 68103-3039 Fax: (402) 231-4310
Funding:	Company funds

APPENDIX B: 2021 STIPEND CREDITS

Applicable to Individuals Who Retire After
November 1, 2020

Age	Retiree Annual Stipend	Spouse Annual Stipend	Supplemental Annual Stipend
Age 55 or older on 1-1-2006	$2,500	$2,250	$600
Age 53 or 54 on 1-1-2006	$2,250*	$1,630*	$600
Age 50 – 52 on 1-1-2006	$1,880*	$1,440*	$910
Age 45 – 49 on 1-1-2006	$1,630*	$1,260*	$1,110
Less than age 45 on 1-1-2006	$1,390*	$1,030*	$1,320

*** Stipend Credits are shown for retirees with 30 or more years of pension service. The starred amounts will be prorated if you retire on or after January 1, 2018 with less than 30 years of pension service. If your amount is subject to this proration, your actual stipend is calculated as follows:**

Amount shown on chart × (Your years of pension service ÷ 30) = Your actual stipend