HOPE GAS, INC. EMPLOYEE BENEFITS FOR UNION EMPLOYEES

ADDITIONAL INFORMATION SUMMARY PLAN DESCRIPTION

EMPLOYEES REPRESENTED

BY

THE UNITED GAS WORKERS' UNION,

LOCAL 69,

UWUA, AFL-CIO

January 1, 2026

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I. INTRODUCTION

This Hope Gas, Inc. Employee Benefits for Union Employees Additional Information Summary Plan Description (the "**Additional Information Summary Plan Description**"), along with the separate summary plan descriptions for each of the Hope Gas, Inc. employee benefit plans for union employees (the "**Union Employee Benefit Plans**"), collectively serves as the Summary Plan Description ("**SPD**") for each of the respective Union Employee Benefit Plans.

The purpose of the Additional Information Summary Plan Description is to provide you with general information regarding the Union Employee Benefit Plans and your rights as applicable under various laws and regulations. Details on rights and procedures for specific Union Employee Benefit Plans may be found in the respective documents governing such benefits. It is important for you to read all components of the SPD for each of the Union Employee Benefit Plans to be fully informed of your coverage and benefits. To the extent that any information contained in this Additional Information Summary Plan Description or in the separate summary plan description for the Union Employee Benefit Plans or any information you receive orally is inconsistent with the official Plan documents, the provisions set forth in the Plan document will govern. The Union Employee Benefit Plans are listed below.

Union Employee Benefit Plans

Plan Name	Plan Number	Benefit	Summary Plan Description
Hope Gas Retirement Savings Plan	001	401(k)	Hope Gas Retirement Savings Plan Summary Plan Description for Union Employees
Hope Gas Pension Plan	002	Pension	Hope Gas Pension Plan for Union Employees Summary Plan Description Hope Gas Pension Plan for Union Employees Summary Plan Description Former Gas Plan Supplement
Hope Gas Health and Welfare Benefit Plan	501	Medical Dental Vision Life/AD&D Voluntary Life Short Term Disability Long-Term Disability Flexible Spending Accounts Business Travel Accident	Medical Dental Vision Life, Business Travel Accident and Voluntary Life Short Term Disability Long-Term Disability Flexible Spending Accounts
Retiree Health and Welfare Plan	N/A	Retiree Medical Health Reimbursement Arrangement Retiree Life	Retiree Medical Health Reimbursement Arrangement Retiree Life
Education		Education	

Plan Name	Plan Number	Benefit	Summary Plan Description
Assistance Program	N/A	Assistance	Education Assistance
Adoption Assistance Program	N/A	Adoption Assistance	Adoption Assistance

You are responsible for verifying that your email address, permanent address, marital status and Beneficiary designation on file are up to date.

The Plan Administrator, or its delegate, has full authority in its sole and absolute discretion, to recover the amount of any payment made to or with respect to a Participant or Beneficiary that exceeds the amount due and payable under the terms of the applicable Union Employee Benefit Plan using any method permitted by law.

II. PLAN SPONSOR AND PLAN ADMINISTRATOR

The "**Plan Sponsor**" and "**Plan Administrator"** for each of the Union Employee Benefit Plans is Hope Gas, Inc. (also referred to in this Additional Information Summary Plan Description as the "**Company**").

Plan Sponsor and Plan Administrator	Hope Gas, Inc.
Address	781 Chestnut Ridge Road, Suite 100 Morgantown, WV 26505
Telephone	(304) 566-2959
Employer Identification Number (EIN)	55-0196830

III. PLAN ADMINISTRATION

Each of the Union Employee Benefit Plans may operate under a specific type of administration and may have a trustee or trustees who oversee the operation of funds of the plan, as applicable.

An annual return is filed with the U.S. Department of Labor on Form 5500 for the Hope Gas Health and Welfare Plan for medical, dental, vision, life/AD&D, voluntary life, short term disability, long term disability, flexible spending accounts and business travel accident benefits. Separate Forms 5500 are filed for the Hope Gas Pension Plan and the Hope Gas Retirement Savings Plan. The Adoption Assistance Program and Education Assistance Program do not require filing a Form 5500.

The Plan Administrator may delegate day-to-day authority and responsibility for administration of the Union Employee Benefit Plans to one or more employees of the Company, and all discretionary actions taken pursuant to any such delegation shall be entitled to the same deference as if taken by the Plan Administrator.

IV. PLAN YEAR

The Plan Year of each of the Union Employee Benefit Plans is the 12-month period beginning each January 1st and ending the following December 31st.

V. YOUR CONTACT AT THE COMPANY

If you have questions or concerns about how a claims administrator is handling or processing your claim, you should make every effort to work with that claims administrator to resolve them. The claims administrators are dedicated to providing excellent service and will be in the best position to respond to your questions or concerns. If you find, however, that after you have made such efforts to work with the claims administrator, you still have such questions or concerns, you can contact the Company's Benefits Manager:

Hope Gas, Inc. Benefits
781 Chestnut Ridge Road, Suite 100
Morgantown, WV 26505
(304) 566-2959
Samantha.j.baxter-nard@hopegas.com

In some instances, the Benefits Manager may be able to answer your questions directly by explaining the claims administrator's processes. In other instances, the Benefits Manager may contact the claims administrator to obtain more details about how your claim is being processed or handled. The Benefits Manager may also be able to help in other ways, such as by facilitating the exchange of information among you, your physician, and the claims administrator. The Benefits Manager also monitors the claims administrator's performance in deciding claims, including its application of appropriate processes. The Benefits Manager does not, however, review or consider whether to overrule any determinations by the claims administrators. The claims administrator makes and reviews all determinations as to whether benefits are payable under the Plan.

VI. UNION

The benefits provided under the Union Employee Benefit Plans described in this Additional Information Summary Plan Description are pursuant to provisions of a collective bargaining agreement entered into between Hope Gas, Inc. and the United Gas Workers Union, Local 69, UWUA, AFL-CIO. You may obtain a copy of the applicable collective bargaining agreement from your Union representative or the Plan Administrator by submitting a written request. Such collective bargaining agreement is also available for inspection at the principal office of the Plan Administrator.

VII. FUNDING FOR THE PLANS

This section describes the means by which the various Union Employee Benefit Plans are funded.

HOPE GAS PENSION PLAN FOR UNION EMPLOYEES

The Hope Gas Pension Plan for Union Employees (the "**Pension Plan**") is a defined benefit pension plan. Depending on your date of hire (or, in some cases, rehire) for purposes of the Pension Plan, your retirement benefits are calculated either through a formula that is based on your age, earnings, years of service and estimated Primary Social Security benefit, or based on the amount of contributions credited to a hypothetical "cash balance" account on your behalf.

The Company will make contributions to the Pension Plan for each year that it is in operation and contributions are required. To accumulate the assets needed to provide you with a benefit, estimates or assumptions are made about your pay, service and life expectancy. Estimates are also made about the future of the economy and the future value of assets already in the Pension Plan. These assumptions are gathered, processed and analyzed by an actuary hired by the Company. The actuary then recommends the amount of contribution needed to fund your benefits.

All Pension Plan assets are held in a trust. The trustee of the trust is responsible for the safekeeping of the trust and to hold and invest Pension Plan assets in a prudent manner and in the best interests of

Pension Plan participants and their beneficiaries. The name of the trust and the trustee and the trustee's contact information are as follows:

Trust: Hope Gas Master Retirement Trust

Trustee: The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60603

HOPE GAS RETIREMENT SAVINGS PLAN

The Hope Gas Retirement Savings Plan (the "**Savings Plan**") is a 401(k) defined contribution plan. It is designed to encourage retirement savings. There is no specific contribution formula under the Savings Plan, although you have a range of pay contribution percentages from which to choose. Company contributions depend on *your* contributions to the Savings Plan and your years of service for purposes of the Savings Plan. A specific retirement benefit is not guaranteed.

The Savings Plan is funded through contributions by you and the Company. Contributions are placed in investment funds according to directions made by you.

The Company's contributions to the Savings Plan are paid to the Savings Plan on the condition that the Savings Plan is qualified under Section 401(a) of the Internal Revenue Code (the "**Code**") and is in compliance with Code Section 401(k). If the Savings Plan is not qualified, Company contributions to your account may be returned. Also, if Company contributions to your account are too large due to an error, the excess amount may be returned to the Company. Except for these limited circumstances, contributions or other Savings Plan assets cannot be returned to the Company.

MEDICAL, DENTAL AND VISION BENEFITS

Medical benefits under the Hope Gas Health and Welfare Benefit Plan are self-funded by the Company. Dental and Vision benefits are fully insured through an insurance company. The Company contributes a significant share of the cost of Medical, Dental and Vision coverage. Your share of the cost is paid through payroll contributions, deductibles and co-payments.

You may elect coverage for (i) you only, (ii) you and your child or children, (iii) you and your spouse or domestic partner, or (iv) you and your family. In general, your payroll contributions for Medical, Dental and Vision coverage are pre-tax deductions. Pre-tax means your contributions are automatically deducted from your pay before Social Security, federal and, in most cases, state taxes are deducted from your paycheck. However, your contributions for Domestic Partner coverage are deducted on an after-tax basis, and are in addition to your pre-tax contributions.

The cost of the Medical, Dental and Vision plans and your payroll contributions are based on actuarial estimates. The amount of your contributions depends on which benefits you select and your coverage level (you only, you and your child or children, etc.). Contributions are adjusted on an annual basis to reflect changes in the cost of coverage.

FLEXIBLE SPENDING ACCOUNTS

You make pre-tax payroll contributions for your benefits under the Flexible Spending Accounts. The amount of your contributions depends on the amount of coverage you select for the Plan Year.

LIFE INSURANCE PLANS

Your Employee Life Insurance coverage in the amount of one-times your base pay and your AD&D coverage are paid for by the Company and insured through Mutual of Omaha.

You pay the full cost of coverage for Supplemental Life and Dependent (Spouse and Child) Life Insurance. These benefits are insured through Mutual of Omaha.

BUSINESS TRAVEL ACCIDENT PLAN

Your Business Travel Accident coverage is paid for by the Company and insured through Zurich American Insurance Company.

LONG-TERM DISABILITY PLAN

Long-Term Disability coverage is self-funded by the Company and administered through Mutual of Omaha. Your coverage of up to 50% of your annual base salary is paid by the Company. You pay the full cost for additional coverage of up to 60% or 70% total coverage on a pre-tax basis or you can purchase coverage of 65% of your annual base salary and pay the full cost on an after-tax basis.

SHORT TERM DISABILITY PLAN

Short-Term Disability coverage is self-funded by the Company and administered through Mutual of Omaha. The Company pays the full cost of this coverage.

EDUCATION ASSISTANCE PROGRAM

The Company pays the full cost of this Program.

ADOPTION ASSISTANCE PROGRAM

The Company pays the full cost of this Program.

RETIREE HEALTH AND WELFARE PLAN

Retiree Medical coverage and Retiree Health Reimbursement Arrangement accounts are self-funded by the Company. Retiree Life Insurance coverage is paid for by the Company and insured by MetLife.

VIII. CHANGING OR TERMINATING THE PLANS

The Company reserves the right to alter, amend, or terminate any of the Union Employee Benefit Plans at any future date. Such alteration, amendment or termination by the Company shall be permitted only after obtaining consent by the Union to such changes, unless the alteration, amendment or termination is needed to comply with law or maintain the qualified status of the Pension Plan or the Savings Plan under the Code, or if it is administrative in nature and does not alter the substantive benefits of the plan(s), in which cases the Company can make such alteration, amendment or termination without consent.

PENSION PLAN

In the case of a complete or partial termination of the Pension Plan, affected participants will have a vested and non-forfeitable right to the accrued benefits they have earned. The amount of your benefit, if any, will depend on the Pension Plan's assets, the terms of the Pension Plan and the benefit guarantee of the Pension Benefit Guaranty Corporation ("**PBGC**"). In the event of plan termination, Pension Plan assets will be distributed among eligible Pension Plan participants and beneficiaries in accordance with provisions of the Employee Retirement Income Security Act ("**ERISA**"). If the Pension Plan is fully funded, you will receive your full accrued benefit.

Once your retirement benefit under the Pension Plan has been determined, it may be paid in the form of one or more cash payments, securities, or an insurance company annuity contract, which will pay you a monthly income. The exact form of payment may be set by law; if there is a choice, the Plan Administrator will decide the type and timing of payment.

SAVINGS PLAN

In the case of a complete or partial termination of the Savings Plan, affected participants will have a fully vested and non-forfeitable right to their account balances. Your account balance may be paid to you in

one or more cash payments. The exact form of payment may be set by law; if there is a choice, the Plan Administrator will decide the type and timing of payment.

IX. THE PENSION BENEFIT GUARANTY CORPORATION

The Pension Benefit Guaranty Corporation ("**PBGC**") insures the benefits guaranteed under defined benefit retirement plans. It does not provide termination insurance for other types of plans (such as our Savings Plan, Medical Plans, Dental Plan, Life Insurance Plans, Vision Plan, Long-Term Disability Plan, or Flexible Spending Accounts).

Your pension benefits under the Pension Plan are insured by the PBGC, a federal insurance agency. If the Pension Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under the Pension Plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the Pension Plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the Pension Plan terminates; (2) some or all of benefit increases and new benefits based on Pension Plan provisions that have been in place for fewer than 5 years at the time the Pension Plan terminates; (3) benefits that are not vested because you have not worked long enough for purposes of the Pension Plan; (4) benefits for which you have not met all of the requirements at the time the Pension Plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Pension Plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Pension Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask the Plan Administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026. You may also call 800-400-7242 or 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 800-400-7242.

You may also contact the PBGC's Customer Contact Center at:

PO Box 151750
Alexandria, VA 22315-1750
Toll-free: 1-800-400-7242

Additional information about the PBGC's pension insurance program is available through the PBGC's website at http://www.pbgc.gov.

X. "TOP-HEAVY" RULES

Under ERISA and the Code, the Pension Plan and the Savings Plans are required to contain provisions that will become operative if they should ever become "top-heavy" sometime in the future.

A plan is considered top-heavy if 60% or more of the value of all the benefits in the plan could be allocated to a small group of highly-paid employees. It is very unlikely that these plans will ever become top-heavy.

XI. QUALIFIED DOMESTIC RELATIONS ORDERS

A Qualified Domestic Relations Order is a legal judgment, decree, or order that recognizes the rights of an alternate payee (such as an ex-spouse or child) under a plan such as the Pension Plan or the Savings

Plans. For example, if you become legally separated or divorced, a portion of your benefit under the Pension Plan or Savings Plans may be assigned pursuant to a Qualified Domestic Relations Order to a former spouse, child, or other dependent.

There are specific requirements the domestic relations order must meet to be recognized by the Plan Administrator, and specific procedures regarding the amount and timing of payments. Information about these requirements and procedures is available without charge by contacting the Plan Administrator. If the Plan Administrator receives such an order relating to your benefit under the Pension Plan or the Savings Plan, the Plan Administrator will notify you.

XII. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Union Employee Benefit Plans will comply with the requirements of a Qualified Medical Child Support Order pursuant to ERISA. A Qualified Medical Child Support Order is a legal judgment, decree, or order that directs a welfare benefit plan (e.g., medical, dental and vision) to cover a child or children of a participant.

For example, if you become legally separated or divorced, you may be required pursuant to a Qualified Medical Child Support Order to obtain coverage for your child(ren) under the medical plan to satisfy your legal obligations.

There are specific requirements that a Qualified Medical Child Support Order must meet to be recognized by the Plan Administrator. Information about these requirements and the process the Union Employee Benefit Plans will follow to determine if an order is valid is available without charge by contacting the Plan Administrator. If the Plan Administrator receives such an order relating to one of your children, the Plan Administrator will notify you.

XIII. YOUR RIGHTS UNDER THE UNION EMPLOYEE BENEFIT PLANS

As provided under ERISA, you have certain rights relative to your participation in the Union Employee Benefit Plans. A description of these rights follow. Additional details concerning your rights under the individual Union Employee Benefit Plans can be found in those respective documents.

CLAIM DENIALS AND APPEALS

Each Summary Plan Description for the Union Employee Benefit Plans contains specific procedures for filing and appealing claims under the benefit plan it describes. All components of the Summary Plan Description for the Union Employee Benefit Plans are furnished to you automatically, without charge. Please refer to the particular Summary Plan Description document for detailed information on filing claims and appeals for the respective Union Employee Benefit Plan. You will be required to follow the appropriate claims and appeal procedures before you may institute legal action against the Union Employee Benefit Plan relating to a claim for benefits.

LEGAL ACTION

If you decide to take legal action related to a claim for benefits or your rights under a plan, the agent to receive legal process is the Plan Administrator. Process should be delivered to:

Hope Gas, Inc.
781 Chestnut Ridge Road, Suite 100
Morgantown, WV 26505
(304) 566-2959
Attn.: General Counsel

The Trustees of the Pension Plan and of the Savings Plan also may receive service of legal process for those respective plans.

YOUR EXCLUSIVE BENEFIT

The benefits provided by the Company plans are intended for the exclusive use of you and your dependents, beneficiaries, or survivors. These benefits may not be assigned, sold, transferred, or pledged by you, or attached or seized by creditors except as permitted by law. For instance, if you are divorced or legally separated, benefit payments from the Pension Plan or the Savings Plan may be made to your divorced spouse, to your child, or other dependent only pursuant to a Qualified Domestic Relations Order.

YOUR RIGHTS PROTECTED

As a participant in the Union Employee Benefit Plans, you are entitled to certain rights and protections under ERISA, including the following rights and protections:

- You may examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Union Employee Benefit Plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed with the U.S. Department of Labor (which Forms 5500 are also available at the Public Disclosure Room of the Employee Benefits Security Administration).
- You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Union Employee Benefit Plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and any updated summary plan descriptions. The Plan Administrator may charge a reasonable fee for the copies.
- You may receive a summary of the Union Employee Benefit Plans' annual financial report, if applicable. The Plan Administrator is generally required by law to furnish each participant with a copy of the summary annual report.
- You may obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) under Pension Plan and if so, what your benefits would be at normal retirement age if you stop working now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan Administrator must provide the statement free of charge.
- You may continue coverage for yourself, your spouse or dependents if there is a loss of coverage under the Medical, Dental, Vision or Health Flexible Spending Account Plans as a result of a qualifying event under COBRA. You or your dependents may have to pay for such coverage. Review this document and the documents governing the applicable Union Employee Benefit Plans on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for participants in the Union Employee Benefit Plans, ERISA imposes duties upon the people who are responsible for their operation. The people, committee or entity who operate the Union Employee Benefit Plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other 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 benefit or exercising your rights under ERISA.

If your claim for a benefit under a Union Employee Benefit Plan is denied in whole or in part, you have a 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. Please refer to the claims and appeal procedures outlined in the Summary Plan Description document for each Union Employee Benefit Plan for

an explanation of the procedures and timelines applicable to such plan. You must fully exhaust a plan's claims and appeal process before you may pursue your claim in court.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator 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 $147 a day (not to exceed $1,427 per request) 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 which is denied or ignored, in whole or in part, after you have exhausted the plan's claims and appeal procedures, you may file suit in a state or federal court.

In addition, if you disagree with a Union Employee Benefit 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 plans' 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 if, for example, it finds your claim is frivolous.

If you have any questions about any of the Union Employee Benefit Plans, you should contact the Plan Administrator or the Hope Gas Benefits Center at (304) 566-2959. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining plan documents from the Plan Administrator, you should contact the nearest Area Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, U.S. Department of Labor, Employee Benefits Security Administration, Public Disclosure Room, 200 Constitution Avenue N.W., Suite N-1515, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling EBSA toll-free at 866-444-EBSA (3272) or 202-693-8673. You may also contact EBSA online at www.dol.gov/ebsa.

Note that if this Additional Information Summary Plan Description or other materials related to the Union Employee Benefit Plans are not consistent with the formal plan documents (including trust agreements and insurance contracts), the provisions of the formal documents will govern. Also, if you notice an error in this Additional Information Summary Plan Description or in any other material related to the Union Employee Benefit Plans, please notify the Hope Gas Benefits Center at (304) 566-2959 immediately.

BENEFIT STATEMENT

Once a year you may request (if you do not already receive) a statement of your benefit under the Pension Plan and the Savings Plans from the Plan Administrator. If you have not yet earned a benefit, the statement will indicate how many more years are needed until you will earn a benefit.

NO GUARANTEE OF EMPLOYMENT

Your participation in these plans may not be interpreted as a guarantee of employment with your employer. Any employee-employer matter will be carried out to the same extent as if the Union Employee Benefit Plans did not exist.

INDEMNIFICATION

To the extent permitted by law, the Company shall indemnify and hold harmless the officers of the Company, the Plan Administrator, and any other person or persons to whom the Company or the Plan Administrator has delegated fiduciary or other duties under the Union Employee Benefit Plans, against any and all claims, losses, damages, expenses and liabilities arising from any act or failure to act that

constitutes or is alleged to constitute a breach of such person's responsibilities in connection with a Union Employee Benefit Plan under ERISA or any other law, unless the same is determined to be due to gross negligence, willful misconduct, willful neglect of duties or willful failure to act; provided that this indemnification will not include any third-party administrators, consultants, contractors or other third parties.

XIV. COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical, Dental, Vision or Healthcare Flexible Spending Account plans (referred to in this Section as the "**COBRA-Eligible Plans**"). This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA under a COBRA-Eligible Plan, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage under a COBRA-Eligible Plan. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of coverage under a COBRA-Eligible Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed in the next section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your covered spouse or domestic partner, and your covered dependent children could become qualified beneficiaries if coverage under the COBRA-Eligible Plan is lost because of the qualifying event.

Generally, COBRA continuation coverage is the same as the coverage in which you were enrolled under the COBRA-Eligible Plan immediately prior to the qualifying event. However, if coverage under the plan is changed for similarly situated active employees under the plan, the same changes will be made for individuals on COBRA continuation coverage.

WHO ARE QUALIFIED BENEFICIARIES?

If you are an employee, you will become a qualified beneficiary if you lose your coverage under a COBRA-Eligible Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under a COBRA-Eligible Plan because any of the following qualifying events happens:

- Your spouse/domestic partner dies (also refer to "Survivor Medical Benefit" in the "Medical" Summary Plan Description document);

- Your spouse/domestic partner's hours of employment are reduced;
- Your spouse/domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse/domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced (final decree must have been granted) from your spouse or you terminate your domestic partner relationship.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies (also refer to "Survivor Medical Benefit" in the "Medical" Summary Plan Description document);
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced (final decree must have been granted); or
- The child stops being eligible for coverage under the plan as a "dependent child."

The option to elect continued coverage under COBRA will not be available in cases of discharge for gross misconduct, as determined by the Company consistent with applicable law.

Subject to the provisions of the Plans regarding the addition of new dependents (such as Open Enrollment and Qualifying Life Event rules), coverage may also be provided for any dependent a covered employee (or former employee) acquires during a period of COBRA continuation coverage. If the new dependent is a child born to or placed for adoption with the covered employee during a COBRA continuation period, that new child will be treated as a qualified beneficiary. Other new dependents, such as new spouses, do not have independent rights as qualified beneficiaries (such as the right to extended coverage due to a second qualifying event).

In certain circumstances, the Company's filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Health and Welfare Benefit Plan or the Retiree Health and Welfare Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Health and Welfare Benefit Plan or the Retiree Health and Welfare Plan.

WHEN IS COBRA COVERAGE MADE AVAILABLE?

The COBRA-Eligible Plans will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the commencement of a proceeding in bankruptcy with respect to the employer, the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Company will notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse, termination of a domestic partner relationship or a dependent child's losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator within 60 days after the qualifying event occurs, or, if later, within 60 days after the

date the coverage would otherwise end due to the qualifying event. You must provide this notice to the COBRA Administrator at the address listed at the end of this section. **If you do not provide this notice within the applicable 60-day period, your spouse or domestic partner and dependents will lose their eligibility for COBRA continuation coverage**.

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries.

HOW LONG IS COBRA COVERAGE PROVIDED?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee's divorce or termination of a domestic partner relationship, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse or domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension

If you or anyone in your family covered under a COBRA-Eligible Plan is determined by the Social Security Administration ("**SSA**") to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

To be eligible for the 11-month extension, you or a family member must provide notice to the COBRA Administrator within 60 days of the SSA disability determination, and in no event later than the end of the first 18-month period of continuation coverage. This notice should be provided to the COBRA Administrator at the address listed at the end of this notice. **If you do not provide this notice within the time frames described above, you, your spouse and dependents will lose the right to the 11-month extension.**

You must also provide notice within 30 days of any subsequent SSA determination that the disabled individual is no longer disabled.

Second Qualifying Event Extension

If your family experiences another qualifying event while receiving 18 or 29 months of COBRA continuation coverage, the spouse, domestic partner and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a total maximum of 36 months of continuation coverage, if notice of the second qualifying event is properly given to the COBRA-Eligible Plan. This extension may be available to the spouse, domestic partner and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or terminates a domestic partner relationship, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have

caused the spouse, domestic partner or dependent child to lose coverage under the plan had the first qualifying event not occurred.

To be eligible for the extension due to a second qualifying event, you or a family member must provide notice to the COBRA Administrator within 60 days of the second qualifying event. This notice should be provided to the COBRA Administrator at the address listed at the end of this notice. **If you do not provide this notice within 60 days, your spouse or domestic partner and dependents will lose the right to the extension.**

Special Rules for Healthcare FSA Coverage

Notwithstanding the above rules, coverage under a Healthcare Flexible Spending Account may be continued only through the end of the calendar year in which the initial qualifying event occurs. Further, you need not be offered COBRA continuation at all if, at the time of the qualifying event, you have already received more in reimbursements than you have contributed to your Healthcare FSA for the year.

Early Termination of COBRA Coverage

In certain circumstances, COBRA continuation coverage may end before the expiration of the applicable continuation periods described above. COBRA continuation coverage for an individual will end on the earliest of the following:

- The end of the applicable 18-, 29- or 36-month period or, in the case of the Healthcare FSA, the end of the calendar year in which the qualifying event occurred.
- The date an election is made to drop coverage. Once coverage is dropped, it cannot be reinstated.
- The date the Company discontinues the COBRA-Eligible Plan. However, if the Company sponsors another similar plan, coverage may be continued under the other plan.
- The date any required premiums are not paid when due (subject to any applicable grace period).
- The date after the date of the election that an individual becomes covered under another group health plan.
- The date after the date of the election that the individual becomes entitled to benefits under Medicare. However, for administrative reasons, only Medical and Healthcare FSA coverage will end; Dental and Vision coverage will continue for the remainder of the original coverage period.
- The month that begins more than 30 days after the date of a final determination by the Social Security Administration that the individual whose disability gave rise to a 29-month continuation period is no longer disabled.
- For any covered non-qualified beneficiaries (i.e., new dependents other than newborn or newly-adopted children who are added to your COBRA coverage after your initial enrollment in COBRA), the date the employee's COBRA continuation period ends.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

Under the COBRA-Eligible Plans, qualified beneficiaries must pay for COBRA continuation coverage. The cost of COBRA continuation coverage is normally 102% of the full cost to the plan of the continued coverage (including both the employer's and employee's contributions).

If coverage is being continued for 29 months on account of disability, the cost of COBRA coverage during the 19th through 29th months is 150% of the full cost to the Plan of the continued coverage. The 150% rate applies to all family members participating in the same coverage option as the disabled individual. Family members participating in a different coverage option than the disabled individual (e.g. a family member who independently selected single coverage while the rest of the family chose family coverage) will continue under the 102% rate. However, if a second qualifying event occurs during the first 18 months of coverage, the premium during the 19th through 36th months will remain at 102%. If a second qualifying event occurs during the 19th through 29th months of coverage, then the premium rate will be 150% for the 19th through 36th months.

Premium amounts are subject to annual adjustment. The Hope Gas Benefits Center can provide you with specific information about the cost of COBRA coverage and payment methods.

WHEN ARE COBRA PAYMENTS DUE?

The first payment for COBRA coverage is due within 45 days of the date you elect to continue coverage. The first payment must cover each full month from the date coverage is lost through the month in which the first payment is made. Thus, the first payment could be for as much as four months of coverage, depending on when you received your election materials and how quickly you returned your election form. Payments for subsequent months are due on the first day of each month, subject to a 30-day grace period. Payments will be considered made on the date they are sent to the Hope Gas Benefits Center based on the postmark.

If you make a timely but incorrect payment in an amount that is not significantly less than your payments due, you will be notified of the amount of the deficiency. You will have 30 days from the date of the notice to pay the full amount owed.

WHAT ARE COBRA'S ELECTION REQUIREMENTS?

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. You must elect to continue coverage within 60 days of either the date coverage would terminate or the date notification of your COBRA election rights is

provided, whichever is later. If no election is made within the applicable 60-day period, you, your spouse or domestic partner and dependents will lose your COBRA rights.

Certain workers who lose their jobs due to foreign trade or competition and become eligible for trade adjustment assistance (TAA) under the Trade Act of 1974 may be given a second 60-day COBRA election period. If you did not make your COBRA election within your first 60-day election period and you are later determined to be TAA-eligible, you will have a second 60-day election period, beginning on the first of the month in which you are determined to be TAA-eligible, to elect COBRA coverage, provided that your election is made with 6 months of your initial loss of coverage. Your COBRA coverage in such case will begin no earlier than the beginning of your second 60-day election period.

CONVERSION PRIVILEGES

At the end of the 18-, 29- or 36-month period, you may be able to convert your medical coverage to an individual policy if you apply within 31 days after the end of the month in which coverage ended. Dependent children who no longer qualify for the Company medical plan may also convert their coverage to an individual policy if they do not wish to purchase COBRA continuation coverage or after their COBRA continuation coverage has ended. The coverage will be different from the Company medical plan and required plan premiums will be paid directly to the insurer or claims administrator.

Please contact the Plan Administrator for additional information on conversion privileges.

There are no conversion privileges for Dental or Vision coverage, or for the Healthcare Spending Account.

IF YOU HAVE QUESTIONS

Questions concerning your COBRA continuation coverage rights should be addressed to the COBRA Administrator at the address and phone number shown below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website, www.dol.gov/ebsa.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Company and the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

COBRA CONTACT INFORMATION

The Company is the COBRA Administrator and is responsible for administering COBRA coverage. Notices and inquiries to the COBRA Administrator should be addressed to the following:

Hope Gas, Inc. Benefits
781 Chestnut Ridge Road, Suite 100
Morgantown, WV 26505
(304) 566-2959
Samantha.j.baxter-nard@hopegas.com

The COBRA Administrator has delegated certain COBRA administrative functions, such as enrollment processing and premium payment administration, to the Hope Gas Benefits Center.

XV. CONTINUING COVERAGE UNDER FMLA

If you have at least one year of service for purposes of the Union Employee Benefit Plans and have worked at least 1,250 hours in the year, you may take unpaid family or medical leave for up to at least 12 weeks during a 12-month period beginning with the start of the first leave. Certain states may allow more than 12 weeks of leave.

ALLOWABLE REASONS FOR LEAVE

This leave may be used for:

- Parenting after the birth of your child (within the first 12 months of the child's life).
- Adoption or foster care of a child (within the first 12 months of adoption of foster placement).
- A serious health condition, either your own or a family member's (spouse, child or parent).
- To care for your spouse, child or parent who is a covered military service member with a serious injury or illness.
- For certain absences necessary because your spouse, child or parent is a covered military service member on active duty or is called or ordered to active duty in support of certain military operations.

YOUR BENEFITS WHILE ON LEAVE

While on unpaid family or medical leave, your elected benefits can continue for up to 12 weeks (or more, depending on your state), to the extent permitted by applicable law and the terms of the Union Employee Benefit Plan(s) in which you participate. If you are on an approved Family and Medical Leave Act (FMLA) leave, and are on paid leave, payroll deductions will continue to be taken. If the employee is on an unpaid leave, benefit premium deductions will be accumulated in the payroll system and will be deducted from the employee's pay upon return to work. If you cancel your coverage during your FMLA leave, you have the right to reinstate your coverage when you return to active work. Automatic benefits continue for up to 12 weeks (or more, depending on your state), except for short-term disability and long-term disability. In most instances, the Company will reinstate you to your current or equivalent position upon your timely return from this type of leave.

ADVANCE NOTICE AND MEDICAL CERTIFICATION

You must provide 30 days' advance notice of your intent to take an unpaid family or medical leave when the leave is "foreseeable." If 30 days' notice is not given and the need and timing of the leave were clearly foreseeable, the Company may delay the leave 30 days. If the leave is requested because of a serious health condition (either your own or a family member's), you must provide a Medical Certification Form to support your request. The Company, at its own expense, may require second or third opinions and may require a "fitness for duty" report prior to your return to work.

Requests for unpaid family or medical leave must be directed to the employee's immediate supervisor. The Company's unpaid family and medical leave policy does not supersede any state or local law that provides greater family or medical leave rights.

For more information on your FMLA rights, contact your local Human Resources manager or see the Family and Medical Leave policy.

XVI. CONTINUING COVERAGE UNDER USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible individuals who enter military service. Generally, if you are on a military leave covered under USERRA, you are entitled to the same rights and benefits that the Company provides to similarly situated employees on other types of leave.

If your military leave is for less than 31 days, you may continue your coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period, you will be charged up to the full cost of coverage plus a 2% administrative fee. The maximum period of continuation coverage available to you and your eligible dependents is the lesser of 36 months or the duration of the leave.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full regularly scheduled work day following your leave, safe transport home and an 8-hour rest period if you are on a military leave of less than 31 days.
- Return to or reapply for reemployment within 14 days of completing your military duty if your absence from work is from 31 to 180 days.
- Return to or reapply for reemployment within 90 days of completing your military duty if your military service is for more than 180 days.

For more information on your USERRA rights, contact your local Human Resources manager or see the Military Leave policy.

XVII. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT NONDISCRIMINATION

The Health Insurance Portability and Accountability Act ("**HIPAA**"), enacted in 1996, limits circumstances that would exclude coverage. Under HIPAA, no medical plan can have enrollment restrictions based on health status-related factors. This means that a health care plan cannot require evidence of insurability and cannot exclude individuals who cannot pass a physical exam.

PRIVACY OF HEALTH INFORMATION

The Union Employee Benefit Plans that are group health plans, including Medical, Dental, Vision and the Healthcare Flexible Spending Accounts Plan, are subject to requirements under HIPAA regarding the privacy of an individual's health information held by such plans. These requirements under HIPAA do not apply to the Company with respect to employment matters or matters other than group health plan administration, nor do they apply to other Union Employee Benefit Plans that are not group health plans.

In general, the HIPAA privacy regulations establish guidelines for and limits upon the group health plans' use and disclosure of your individual health information held by the plans. The plans have implemented privacy policies and procedures to ensure the privacy of your health information, as required under the regulations. In addition, the Company has amended the applicable Union Employee Benefit Plan documents to ensure that Company employees who receive or have access to health information from the group health plans protect the privacy of that information, as required by HIPAA.

The group health plans subject to the HIPAA privacy regulations have prepared a Notice of Privacy Practices that describes the manner in which your health information may be used and disclosed by the group health plans and explains your legal rights under the regulations. All of the group health plans sponsored by the Company jointly maintain this Notice of Privacy Practices. You may request a copy of the plans' Notice of Privacy Practices or file a complaint where you feel your privacy rights have been violated by contacting the Hope Gas Benefits Center at (304) 566-2959.