

APPENDIX F

MEDICAL, DENTAL & VISION BENEFIT AGREEMENT

BETWEEN
SOUTHERN CALIFORNIA GAS COMPANY
AND
UTILITY WORKERS UNION OF AMERICA, AFL-CIO
INTERNATIONAL CHEMICAL WORKERS UNION COUNCIL,
UFCW, AFL-CIO

November 5, 2021

MEDICAL, DENTAL AND VISION BENEFIT AGREEMENT

This Agreement, made and entered into at Los Angeles California, as of **November 5, 2021**, by and between Southern California Gas Company, a California corporation, with its principal place of business at 555 West Fifth Street, in said City and State, party of the first part, hereinafter referred to as the “Company,” and the Utility Workers Union of America, AFL-CIO, and International Chemical Workers **Union** Council, UFCW, AFL-CIO, parties of the second part, hereinafter referred to as the Union.”

WITNESSETH:

That it is the intent and purpose of the parties hereto to incorporate herein the provisions of the Company’s Medical, Dental and Vision Plan, hereinafter referred to as the “Plan,” and that this Agreement, arrived at through the process of collective bargaining in the manner provided by law, represents the determination of all issues pertaining directly or indirectly to the subject of Medical, Dental and Vision Benefits for employees covered by this Agreement, and sets forth herein the agreement relating to such benefits to be observed between the parties hereto and that said parties to this Agreement, acting through their respective duly authorized representatives, promise and agree as follows:

The provisions of this Agreement shall apply to all employees who are covered by that certain Agreement between the parties hereto dated **November 5, 2021**, covering rates of pay, hours of work and conditions of employment, or by said Agreement as it may be subsequently modified, or by any superseding agreement.

MEDICAL, DENTAL AND VISION BENEFITS AGREEMENT

This Agreement sets forth the terms and conditions of Medical, Dental and Vision Benefits from **November 5, 2021** through the term of the agreement.

Health Maintenance Organizations:

All eligible **Full-Time** employees shall be entitled to choose from the **three** health maintenance organizations (HMOs) which have coverage in their geographic area: **Anthem Blue Cross Select HMO**, Anthem Blue Cross CaliforniaCare and Kaiser.

The basic coverage and base costs of HMO coverage are set forth in the attached Summary of Medical Plan Provisions. Those basic provisions, as described by the HMO's own summary plan descriptions, may be modified from time to time by the specific HMO to meet legal requirements, or as designated by law, or annually to meet business requirements. If not specified by the HMO, or as required by law, the Company may not modify the provisions within this Agreement.

Medical Plan Options - General:

For employees in the Anthem Blue Cross network service area, the Company, in addition to offering HMOs, shall offer the following option: **the Anthem Health Care Plus⁺ with a related Health Savings Account**. Other than required employee contributions, co-pays, **balance bills** and deductibles, as applicable, the Company agrees to pay the full cost of medical plans. The basic provisions of the medical plans are agreed to as provided in the Summary of Medical Plan Provisions as provided in Tables I through III.

Anthem Health Care Plus⁺ Plan with a related Health Savings Account and other components:

Anthem Health Care Plus⁺ Plan

The Company shall offer the Anthem Health Care Plus⁺ Plan. The Company shall pay the cost, other than employee contributions, co-insurance, and deductibles, for the High Deductible/PPO/indemnity-type plan. The basic terms of the Anthem Health Care Plus⁺ Plan are agreed to be as stated in the Summary of Medical Plan Provisions as provided in Table II. Those basic provisions, as described in the summary plan descriptions, may be modified from time to time to meet legal requirements, or as designated by law, or annually to meet business requirements. If not specified by the Anthem, or as required by law, the Company may not modify the provisions within this Agreement.

Should the Internal Revenue Service (IRS) minimum deductible for a high deductible health plan exceed the Anthem Health Care Plus⁺ Plan, the Anthem Health Care Plus⁺ Plan deductible will increase to meet the minimum required. The out-of-pocket maximum

will also increase to be 2 times the annual deductible in accordance with applicable IRS and other regulatory requirements.

Health Savings Account

The Company shall offer a Health Savings Account with the Anthem Health Care Plus⁺ Plan. The Health Savings Account is owned by the employee and may be funded with company and employee contributions up to the limits and provisions provided by the IRS Code each year. Company will contribute the following amounts to the HSA: \$500 for Employee Only coverage and \$1,000 for Employee + Dependent(s) coverages.

Out of Area Plan:

The Company shall pay the cost, other than employee contributions, co-insurance and deductibles, for a **high deductible/PPO/indemnity-type health plan or the Anthem Health Care Plus⁺ Plan with a related Health Savings Account, in areas not served by an HMO.** The basic terms of the Out-of-Area Plan are agreed to be as stated in the Summary of Medical Plan Provisions as provided in Table II. HMO Plan options shall replace this plan immediately when a network expands to these areas, subject to an employee's 30-day election rights.

For pre-age 65 retirees in the Blythe and Needles areas, the Company, in addition to offering HMOs shall offer the Out of Area and **Anthem Health Care Plus⁺ Plan** with provisions as agreed to as stated in the Summary of Medical Plan Provisions (see Table II). **Those basic provisions, as described in the summary plan descriptions, may be modified from time to time to meet legal requirements, or as designated by law, or annually to meet business requirements. If not specified by the Anthem, or as required by law, the Company may not modify the provisions within this Agreement.** The retiree contributions shall be as stated in the Summary of Medical Plan Provisions attached hereto.

Expansion of HMO and Anthem Health Care Plus⁺ Plan Networks:

It is understood by the Union and the Company that the HMOs and **Anthem Health Care Plus⁺** Plan networks may expand to service areas not presently covered. In the event that the network expands into an area covered by the Out of Area Plan, such that instead of zero primary care physicians in the area there are one or more primary care physicians, the employee shall have thirty days in which to elect the **Anthem Health Care Plus⁺ Plan** or one of the HMO plans.

Benefit Plan Options for Part-Time Employees:

The Company shall offer Part-Time employees the choice of either the Anthem Blue Cross Select HMO, Anthem Blue Cross CaliforniaCare or the Kaiser HMO, MetLife Dental and MetLife Vision. Other than required employee contributions, co-pays, balance bills and deductibles, as applicable, the Company agrees to pay the full cost of medical plans. Those eligible part-time employees who waive Medical, Dental and Vision benefits will not receive a credit.

Part-Time Eligibility

The Company shall commence medical, dental, and vision benefits for all Part-Time employees who are offered coverage on the first of the month, following 60 days after the date of continuous service. There will be no additional waiting period for employees who have already met this requirement, such as an employee who transfers from a part-time position to a full-time position.

Married Employees:

If two Company employees are married to one another, they may enroll individually, or one may enroll as the dependent of the other, whichever is financially beneficial for the employee.

Domestic Partners:

Domestic Partners of employees will be eligible for dependent coverage under the Medical, Dental and Vision Plans. Domestic Partners are defined as “two adults of the same or opposite sex who have chosen to share their lives in an intimate and committed relationship, reside together, and share a mutual obligation of support for the basic necessities of life.” Employees must complete and sign an affidavit affirming the relationship or submit a California Registration of Domestic Partnership.

An affidavit or California Termination of Domestic Partnership is also required in the event the domestic partner relationship terminates. Employee contribution amounts will be the same as for current dependent coverage. Employees are subject to any imputed income tax as a result of covering a domestic partner.

Medical Coverage (including Prescription Drugs):

Summaries of the various medical plan coverage provisions are included in Table I – Health Maintenance Organizations; and Table II **Anthem Health Care Plus⁺ Plan** and Anthem Blue Cross Out-of-Area PPO Plan.

Represented employees under 65 who retire **on or after November 5, 2021**, and their eligible dependents, shall have the same medical plan options as active employees.

Employee Assistance Plan, Mental Health and Substance Abuse Benefits:

A summary of EAP, mental health and substance abuse benefits is provided in Table **III**– Summary of Employee Assistance Plan, Mental Health and Substance Abuse benefits.

Dental Coverage:

The Company shall offer Delta Dental in addition to the **MetLife** Dental Plan. The basic provisions of the dental plans are agreed to as provided in Table **VI** – Summary of Dental Plan Provisions attached hereto.

The Company will pay the full cost of the **MetLife** Dental plan for all coverage levels (Employee only, Employee plus one dependent, Employee plus two or more dependents) and will contribute an equal amount toward the Delta plan. Employees will pay the amount that exceeds the cost of the equivalent **MetLife** coverage.

Vision Coverage:

The Company will offer the Vision Service Plan **Standard and Vision Service Plan Premium** in addition to the **MetLife Vision Plan**. The basic provisions of the vision plans are agreed to as provided in Table V – Summary of Vision Benefits attached hereto. The Company shall pay the full premium for employee coverage; employees pay the full premium for dependent coverage.

Full-time Eligibility for Medical, Dental and Vision Benefits:

The Company shall commence medical, dental, and vision for all Full-time employees who are offered coverage on the first of the month, following their date of employment. There will be no additional waiting period for employees who have already met this requirement, such as an employee who transfers from a part-time position to a full-time position.

Retiree Benefits – Medical Plans:

Represented employees under age 65, **who retire on or after November 5, 2021**, including their eligible dependents, may elect to participate in the same plans provided to active employees.

Represented employees over age 65, **who retire on or after November 5, 2021**, may elect to participate in the Kaiser Senior Advantage Plan, UnitedHealthcare Medicare Advantage **HMO**, UnitedHealthcare Plan F or UnitedHealthcare Plan N upon attainment of eligibility for Medicare Part A and Part B.

A summary of retiree medical plan provisions for retirees age 65 or older is provided in Table VII– Summary of Retiree Medical Benefits for Post Age-65 Retirees who retire on or after **November 5, 2021**.

Health Reimbursement Accounts:

The Company provides a Healthcare Reimbursement Account for all eligible represented employees. A copy of the Southern California Gas Company Healthcare Reimbursement Account Plan for Represented Retirees is included as Attachment A.

Medical, Dental and Vision Cost Share:

The Company will provide an annual summary of all benefit plan rates for union members prior to the Company’s annual open enrollment period.

A summary of active medical, dental and vision benefit cost sharing is provided in Table VI – Summary of Medical, Dental and Vision Benefit Cost Sharing for Active Employees.

A summary of retiree monthly cost contributions is provided in Table **VIII** – Summary of Monthly Retiree Medical and Dental Benefit Cost Sharing for Pre Age-65 and Post Age-65 Retirees who retire on or after **November 5, 2021**.

Table I – Health Maintenance Organizations (HMO Plans)

Description	Anthem Blue Cross CaliforniaCare	Anthem Select HMO	Kaiser Permanente
Who Provides Care	All care coordinated by your primary care physician	All care coordinated by your primary care physician	You must use Kaiser physicians and hospitals
Annual Deductible	None	None	None
Annual Out-of-Pocket Maximum	\$2,000 per person; \$6,000 per family	\$2,000 per person; \$6,000 per family	\$1,500 per person; \$3,000 per family
Network Area	Based on home or work ZIP code	Based on home or work ZIP code	Based on home or work ZIP code
Benefits for Most Covered Services	Plan pays 100% of covered expenses. There is no deductible, but copays are required in many cases	Plan pays 100% of covered expenses. There is no deductible, but copays are required in many cases	Plan pays 100% of covered expenses. There is no deductible, but copays are required in many cases
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Physician Office Visits and Home Visits	You pay \$20 copay for PCP; \$40 copay for specialist	You pay \$20 copay for primary care PCP; \$40 copay for a specialist	You pay \$20 copay. No charge for scheduled prenatal or for home visits
Preventative Routine Physical Exams and Well-Baby Care	No charge	No charge	No charge
Inpatient Hospital Services	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses
Outpatient Testing (Laboratory Tests, X-rays, Pathology)	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses
Surgeons, Assistant Surgeons, Anesthesiologists	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses
Emergency Room Services	You pay \$250 (waived if admitted). Non-emergency care is not covered	You pay \$250 copy (waived if admitted)	You pay \$150 copay (waived if admitted) at Kaiser or other facility for emergency You pay \$150 copay for non-emergency care at a Kaiser facility; otherwise not covered

Description	Anthem Blue Cross CaliforniaCare	Anthem Select HMO	Kaiser Permanente
Urgent Care	You pay \$40 copay if associated with primary medical group or authorized by primary care physician	You pay \$40 copay if associated with Primary Medical Group (PMG) or authorized by PCP	You pay \$20 copay at Kaiser
Rental of Medical Equipment	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses when approved by Kaiser physician
Chiropractic Care	Not covered	You pay \$40 copay if authorized by your PMG or PCP	Not covered
Specified Immunizations	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses

Table I – Health Maintenance Organizations (HMO Plans) (Continued)

Description	Anthem Blue Cross CaliforniaCare	Anthem Select HMO	Kaiser Permanente
Prescription Drugs	<p>You pay \$10 copay for generic, \$25 copay preferred brand and \$50 co-pay for non-preferred drugs for 30-day supply at participating pharmacies.</p> <p>Mail order: You pay two times the copay for a 90-day supply.</p> <p>Your cost will be higher at nonparticipating pharmacies</p>	<p>You pay \$10 copay for generic, \$25 copay for brand and \$50 copay for non-preferred drugs for 30-day supply.</p> <p>Mail order: You pay 2 times the copay for 90-day supply.</p> <p>Your cost will be higher at nonparticipating pharmacies</p>	<p>You pay \$10 copay for generic and \$20 brand for 100-day supply at Kaiser pharmacy, through mail order, or online at the Kaiser website</p>
Mental Health and Substance Abuse	<p>Mental health and substance abuse benefits have the same level of coverage, copays and deductibles as other benefits in the medical plan in which you are enrolled.</p>	<p>Mental health and substance abuse benefits have the same level of coverage, copays and deductibles as other benefits in the medical plan in which you are enrolled.</p>	<p>Mental health and substance abuse benefits have the same level of coverage, copays and deductibles as other benefits in the medical plan in which you are enrolled.</p>

Table II – Anthem Health Care Plus⁺ Plan and Anthem Blue Cross Out-of-Area Plan

Description	ANTHEM BLUE CROSS			
	Anthem Health Care Plus ⁺		Out-of-Area	
	Network	Non-Network	Network	Non-Network
Who Provides Care	Care provided by any Prudent Buyer network doctor or hospital	Care provided by any provider you choose	Care provided by Prudent Buyer network doctor or hospital	Care provided by any provider you choose
Annual Deductible	\$1,500 per person; \$3,000 per family	\$3,000 per person; \$6,000 per family	\$300 per person; \$900 per family	\$1,000 per person; \$3,000 per family
Annual Out-of-Pocket Maximum	\$3,000 per person; \$6,000 per family	\$6,000 person; \$12,000 per family	\$2,000 per person; \$6,000 family	\$4,000 per person \$12,000 per family
Network Area	Nationwide coverage. Network providers may not be available in all areas	Nationwide coverage	Available only if you do not live in the CaliforniaCare service area	
Benefits for Most Covered Services	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary expenses, after deductible	Plan pays 100% of covered expenses after deductible, but copays are	Plan pays 80% of usual and customary charges, after deductible

Description	ANTHEM BLUE CROSS			
	Anthem Health Care Plus ⁺		Out-of-Area	
	Network	Non-Network	Network	Non-Network
			required in many cases	
Lifetime Maximum	Unlimited		Unlimited	
Physician Office Visits and Home Visits	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary expenses, after deductible	You pay \$20 copay	Plan pays 80% of usual and customary charges after deductible
Preventative Routine Annual Wellness Physical Exams	Plan pays 100%; no deductible applies	Plan pays 60% of usual and customary expenses, after deductible	Plan pays 100%; no deductible applies	Not covered
Inpatient Hospital Services	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary expenses, after deductible	Plan pays 100% of covered expenses after deductible applies	Plan pays 80% of usual and customary charges after deductible
Outpatient Testing (Laboratory Tests, X-rays, Pathology)	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary expenses, after deductible	Plan pays 100% of covered expenses	Plan pays 80% of usual and customary charges after deductible
Surgeons, Assistant Surgeons, Anesthesiologists	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary expenses, after deductible	Plan pays 100% of covered expenses after deductible	Plan pays 80% of usual and customary charges after deductible
Emergency Room Services	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary expenses, after deductible	You pay \$250 copay (waived if admitted)	
Urgent Care	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary expenses, after deductible	You pay \$40 copay	Plan pays 80% of usual and customary charges after deductible
Rental of Medical Equipment	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary expenses, after deductible	Plan pays 80% of usual and customary charges after deductible	
Chiropractic Care	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary expenses, after deductible, up to \$25 maximum benefit per visit	You pay \$20 copay	Plan pays 80% of usual and customary charges after deductible, up to \$28 maximum benefit per visit
	Maximum of 24 visits per year combined for Physical Therapy, Occupational Therapy, and Chiropractic Care		Combined maximum of 25 visits per year	
Specified Immunizations	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual & customary	Included in \$20 office visit copay	Not covered

Description	ANTHEM BLUE CROSS			
	Anthem Health Care Plus ⁺		Out-of-Area	
	Network	Non-Network	Network	Non-Network
		expenses, after deductible		

Table II – Anthem Health Care Plus⁺ Plan and Anthem Blue Cross Out-of-Area Plan (Continued)

Description	ANTHEM BLUE CROSS			
	Anthem Health Care Plus ⁺		Out-of-Area	
	Network	Non-Network	Network	Non-Network
Preventative Immunizations	Plan pays 100%, deductible waived	Plan pays 60% of usual and customary expenses, after deductible	Plan pays 100% of covered expenses	Not covered
Prescription Drugs	You pay \$5 copay and \$10 mail order copay for preventative drugs. Plan pays 80% of contracted fee after deductible, for all other drugs. Mail order is available.	Plan pays 60% of usual and customary expenses, after deductible. Mail order prescription drugs are not covered if a non-network provider is used.	You pay \$10 copay for generic, \$25 copay for preferred brand and \$50 copay for non-preferred drugs for 30-day supply at participating pharmacies. Mail Order: You pay two times the copay for 90-day supply. Your cost will be higher at nonparticipating pharmacies.	
Mental Health and Substance Abuse	Mental health and substance abuse benefits have the same level of coverage, copays and deductibles as other benefits in the medical plan in which you are enrolled.	Mental health and substance abuse benefits have the same level of coverage, copays and deductibles as other benefits in the medical plan in which you are enrolled.	Mental health and substance abuse benefits have the same level of coverage, copays and deductibles as other benefits in the medical plan in which you are enrolled.	

Medical Plan – Mental Health:

For employees enrolled in any Anthem Blue Cross of California plan, the Medical Plan basic provisions regarding mental health coverage are agreed to as provided in the following summary table or as prescribed by law when applicable:

Table III – Summary of Medical Plan Mental Health Coverage

Description	Anthem Blue Cross California Care HMO		Anthem Select HMO		Kaiser HMO	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Outpatient	\$20 copay	No Benefit	\$20 copay	No Benefit	\$20 copay	No Benefit
Subacute Benefit	100% paid	No Benefit	100% paid	No Benefit	100% paid	No Benefit
Hospital Benefit	100% covered	Emergency Only	100% covered	Emergency Only	100% covered	Emergency Only
Deductible	None		None		None	
Out-of-Pocket Maximum (includes deductible)	\$2,000 person; \$6,000 family		\$2,000 person; \$6,000 family		\$1,500 per person; \$3,000 per family	
Emergency Room	You pay \$250 copay; waived if admitted		You pay \$250 copay; waived if admitted		You pay a \$150 copay (waived if admitted) at Kaiser or any other facility used for an emergency	
Ambulance	100% Covered		100% Covered		100% Covered	
Skilled Nursing Facility Annual Maximum	Skilled Nursing 100 days per year for medical	No Benefit	Skilled Nursing 100 days per year for medical	No Benefit	Skilled Nursing 100 days per year for medical	No Benefit
Lifetime Maximum	Unlimited		Unlimited		Unlimited	

Table III – Summary of Medical Plan Mental Health Coverage (Continued)

Description	Anthem Health Care Plus ⁺		Anthem Blue Cross Out-of-Area	
	Network	Non-Network	Network	Non-Network
Outpatient	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary after deductible	\$20 copay	80% of usual & customary after deductible
Subacute Benefit	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary after deductible	100% of covered expenses	80% of usual & customary after deductible
Hospital Benefit	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary after deductible	100% of covered expenses	80% of usual & customary after deductible
Deductible	\$1,500 per person \$3,000 per family	\$3,000 per person \$6,000 per family	\$300 per person; \$900 per family	\$1,000 per person; \$3,000 per family
Out of Pocket Maximum	\$3,000 per person; includes deductible \$6,000 per family; Includes deductible	\$6,000 per person; includes deductible \$12,000 per family; includes deductible	\$1,500 per person; \$4,500 family	\$3,000 per person; \$9,000 family
Emergency Room	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary after deductible	You pay a \$250 copay (waived if admitted)	80% of usual & customary after deductible
Ambulance	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary after deductible	80% of usual & customary after deductible	80% of usual & customary after deductible
Skilled Nursing Facility Annual Maximum	Plan pays 80% of contracted fee, after deductible	Plan pays 60% of usual and customary after deductible	Skilled Nursing 100 days per year	

Table IV – Dental Benefits

Description	MetLife	Delta Dental	
	(California)	Network	Non-Network
Who Provides Care	All care coordinated by your primary dentist	Services provided by a Delta Dental PPO network dentist	Services provided by a Delta Dental (non-PPO) dentist or a non-Delta Dental dentist
Annual Deductible	None	Except for Diagnostic and Preventive services; \$100 per individual \$300 per family	
Annual Benefit Maximum	None	\$2,000 per individual	
Diagnostic and Preventive Services	Plan pays 100% of Preventive and many Basic Services. Other services require a copay.	Plan pays 100% with no deductible	Plan pays 50% with no deductible
Basic Services		After deductible, Plan pays 80%	After deductible, Plan pays 50%
Major Services		After deductible, Plan pays 60%	After deductible, Plan pays 50%
Prosthodontic Services		After deductible, Plan pays 60%	After deductible, Plan pays 50%
Orthodontics	Plan pays 50% of covered expenses with no deductible; \$1,500 lifetime benefit maximum per person		

Table V – Vision Benefits

Description	Vision Service Plan Standard		Vision Service Plan Premium		MetLife	
	VSP Provider	Non-VSP Provider	VSP Provider	Non-VSP Provider	MetLife Provider	Non-MetLife Provider
Who provides care	Any VSP provider	Any provider	Any VSP provider	Any provider	Any MetLife provider	Any provider
Copays	You pay a \$40 copay maximum (\$15/eye exam and \$25/materials). You are responsible for all amounts in excess of the covered expense		You pay \$10 copay for eye exam and/or glasses. You are responsible for all amounts in excess of the covered expenses for exams and materials	You pay \$10 copay for eye exam and/or glasses. You are responsible for all amounts in excess of the covered expenses for exams and materials	You pay a \$15 copay for standard vision care and services.	Plan pays \$35 for an exam once every 12 months. You are responsible for all amounts in excess of the plan covered expense.
Eye Examination	Plan pays 100% less any applicable copayment every calendar year	Plan pays up to \$50 for one eye exam every calendar year	Plan pays 100% for one eye exam every calendar year after copay	Plan pays up to \$50 for eye exam every calendar year after copay	Plan pays 100% for one eye exam every 12 months.	
Corrective Lenses	Plan pays 100% of covered expenses less any copayment for one pair every calendar year.	Plan pays the following amounts for one pair every calendar year : <ul style="list-style-type: none"> • Single – Up to \$50 • Bifocal – up to \$75 • Trifocal – up to \$100 • Lenticular – up to \$125 	Plan pays 100% of covered expenses after copay for single vision, bifocal, or trifocal lenses every calendar year	Plan pays the following amounts for one pair every calendar year: <ul style="list-style-type: none"> • Single – Up to \$50 • Bifocal – up to \$75 • Trifocal – up to \$100 • Lenticular – up to \$125 	Plan pays for one pair every 12 months if prescription change so indicates.	Plan pays the following amounts for one pair every 12 months: <ul style="list-style-type: none"> • Single – up to \$25 • Bifocal – up to \$35 • Trifocal – up to \$45 • Lenticular – up to \$100
Frames	Plan pays 100% of covered expenses after any applicable copayment	Plan pays retail cost up to \$70 every other calendar year . You	Every calendar year \$160 allowance for a wide selection of frames, \$180 allowance for featured frame brands, and 20%	Plan pays retail cost up to \$70 once every calendar year . You pay cost over \$70 .	Plan pays 100% of selected frames up to \$120 once every 24 months.	Plan pays \$65 every 24 months.

	every other calendar year You are responsible for anything over the \$260 frame allowance minus 20%	pay cost over \$70.	savings on the amount over your allowance		You pay 75% of retail cost over \$120.	
Contact Lenses Medically Necessary	Plan pays 100% after applicable copay for one pair every calendar year	Plan pays up to \$210 every calendar year	Plan pays 100% after applicable copay for one pair every calendar year	Plan pays up to \$210 for one pair every calendar year	Plan pays 100% every 24 months if prescription changes so indicates.	Plan pays \$250 allowance.
Elective	Plan pays up to \$120 every calendar year	Plan pays up to \$120 every calendar year	Plan pays \$160 allowance every calendar year	Plan pays up to \$130 every calendar year	Plan pays \$75 allowance.	Plan pays \$56 allowance.
Upgrades			<u>Choice of one upgrade available:</u> <ul style="list-style-type: none"> • Increase frame allowance to \$260 • Increase contact lens allowance to \$230 • Fully covered anti-reflective coating • Fully covered progressive lenses • Fully covered photochromic adaptive lenses 	N/A		

Table V – Vision Benefits (Continued)

Description	Vision Service Plan Standard		Vision Service Plan Premium		MetLife	
	VSP Provider	Non-VSP Provider	VSP Provider	Non-VSP Provider	MetLife Provider	Non-MetLife Provider
Filing Claims	You do not need to file a claim if you use a VSP Provider.	If you use a non-VSP provider, you must submit a claim form, itemized bill and a copy of receipt of payment to VSP within six months of service.	You do not need to file a claim if you use a VSP Provider.	If you use a non-VSP provider, you must submit a claim form, itemized bill and a copy of receipt of payment to VSP within six months of service.	You do not need to file a claim if you use a MetLife provider.	After you pay the non-MetLife provider, you must submit an itemized bill and copy of receipt of payment to MetLife within six months.
Low-Vision Benefit	Supplementary testing is covered in full and supplemental care is covered at 75% of the cost, to a maximum of \$1,000 every two years.	You pay the non-network doctor in full and VSP will reimburse you the amount VSP would have paid a network doctor.	Supplementary testing is covered in full and supplemental care is covered at 75% of the cost, to a maximum of \$1,000 every two years.	You pay the non-network doctor in full and VSP will reimburse you the amount VSP would have paid a network doctor.	Refer to MetLife Evidence of Coverage Booklet for details.	Refer to Provider for assistance.

Table VI– Summary of Medical, Dental and Vision Benefit Cost Sharing for Active Employees

Full-time Employees:

	Company Pays	Employee Pays
Medical		
Kaiser Permanente	84% of the total premium rates	16% of the total premium rates
Anthem Blue Cross Select HMO	82% of the total premium rates	18% of the total premium rates
Anthem Blue Cross California Care HMO	75% of the total premium rates	25% of the total premium rates
Anthem Blue Cross Health Care Plus +	90% of the total premium rates	10% of the total premium rates
Anthem Blue Cross Out of Area	80% of the total premium rates	20% of the total premium rates
Dental		
MetLife Dental	100% of the total MetLife Dental premium rates	0% of the total MetLife Dental premium rates
Delta Dental	100% of the total MetLife Dental premium rates	Difference between the MetLife Dental total premium rates and the Delta Dental total premium rates
Vision		
MetLife Vision	100% of the EE Only total premium rate	Difference between total premium rate and EE Only total premium rate
Vision Service Plan Standard	100% of the EE Only total premium rate	Difference between total premium rate and EE Only total premium rate
Vision Service Plan Premium	100% of the Vision Service Plan Standard EE Only total premium rate	Difference between total premium rate and Vision Service Plan Standard EE Only total premium rate

Part-time Employees:

	Company Pays	Employee Pays
Medical		
Kaiser Permanente	84% of the EE Only total premium rate	Difference between total premium rates and 84% of the EE Only total premium rate
Anthem Blue Cross Select HMO	82% of the EE Only total premium rate	Difference between total premium rates and 82% of the EE Only total premium rate
Anthem Blue Cross California Care HMO	75% of the EE Only total premium rate	Difference between total premium rates and 75% of the EE Only total premium rate
Dental		
Metlife Dental	100% of the total MetLife Dental EE Only premium rate	Difference between the total premium rates and MetLife Dental EE Only total premium rate
Vision		
MetLife Vision	100% of the EE Only total premium rate	Difference between total premium rate and EE Only total premium rate

Table VII – Summary of Retiree Medical Benefits for Post Age-65 Retirees who retire on or after November 5, 2021

Description	UnitedHealthcare Medicare Advantage	Kaiser Senior Advantage
Who Provides Care	All care coordinated by your primary care physician	You must use Kaiser physicians and hospitals
Annual Deductible	None	None
Annual Out-of-Pocket Maximum	\$6,700	\$1,500 per person; \$3,000 per family
Network Area	Based on home ZIP code	Based on home ZIP code
Benefits for Most Covered Services	Plan pays 100% of covered expenses. There is no deductible, but copays are required in many cases	Plan pays 100% of covered expenses. There is no deductible, but copays are required in many cases
Physician Office Visits and Home Visits	You pay \$5 copay	You pay \$5 copay.
Inpatient Hospital Services	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses
Outpatient Testing (Laboratory Tests, X-rays, Pathology)	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses
Surgeons, Assistant Surgeons, Anesthesiologists	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses

Table VII – Summary of Retiree Medical Benefits for Post Age-65 Retirees who retire on or after November 5, 2021 (continued)

Description	UnitedHealthcare Medicare Advantage	Kaiser Senior Advantage
Emergency Room Services	You pay \$50 copay (waived if admitted).	You pay \$20 copay (waived if admitted) You pay \$20 copay for non-emergency care at a Kaiser facility; otherwise not covered
Urgent Care	You pay \$5 copay if affiliated with your medical group; otherwise treated as emergency	You pay \$5 copay at Kaiser
Durable Medical Equipment	Plan pays 100% of covered expenses	Plan pays 100% of covered expenses
Skilled Nursing Facility	Plan pays 100% of covered expenses for up to 100 days per benefit period	Plan pays 100% of covered expenses for up to 100 days per benefit period
Home Health Care	Plan pays 100% of covered expenses when part of a prescribed home health care program	Plan pays 100% of covered expenses when referred by Kaiser’s Home Health Services
Hearing Services	Routine hearing exam - \$20 one per year. Diagnoses and treat hearing and balance issues - \$5 copay. Hearing aids \$500 allowance every 3 years. Only available through UHC Hearing	Hearing exam \$5 copay
Diabetes	Plan pays 100% for self-management training	
Prescription Drugs	You pay \$7 copay for generic, \$14 copay for brand for 30-day supply, or two times the copay for a 90 day supply through mail order	You pay \$5 copay for generic and brand for 100-day supply of drugs from formulary at Kaiser pharmacy, through mail order, or online at the Kaiser website
Mental Health and Substance Abuse	Provided through UnitedHealthcare Medicare Advantage (Secure Horizons)	Provided through Kaiser Senior Advantage
	Due to the Mental Health Parity and Addiction Equity Act, Mental Health and Substance Abuse benefits are required to mirror the medical plan in which you are enrolled. Please contact the Mental Health and Substance Abuse carrier, Kaiser Senior Advantage or United Healthcare HMO, for more information on the coverage.	

Table VII – Summary of Retiree Medical Benefits for Post Age-65 Retirees who retire on or after November 5, 2021 (continued)

Description	UnitedHealthcare – Plan N	UnitedHealthcare – Plan F
Who Provides Care	Care coordinated with Medicare. There is no required network. All Medicare participating providers are accepted.	Care coordinated with Medicare. There is no required network. All Medicare participating providers are accepted.
Medicare Enrollment	Member must be enrolled in Medicare Part A and Part B	Member must be enrolled in Medicare Part A and Part B
Annual Deductible	Not applicable	Not applicable
Annual Out-of-Pocket Limit	\$6,700	No Out of Pocket Expense for covered services
Benefits for Most Covered Services	Member pays Medicare Part B deductible and applicable copayments/coinsurance as outlined below.	Member pays \$0 of Medicare allowable balance remaining after Medicare payment
Lifetime Maximum	Unlimited	Unlimited
Physician Office Visits and Home Visits	Member pays \$20 office visit copay	Member pays \$0 of Medicare allowable balance remaining after Medicare payment
Inpatient Hospital Services	Member pays \$0 of Medicare-covered hospital stay	Member pays \$0 of Medicare-covered hospital stay.
Outpatient Testing (Laboratory Tests, X-rays, Pathology)	Member pays \$0 copay	Member pays \$0 copay
Surgeons, Assistant Surgeons, Anesthesiologists	Member pays 50% of Medicare Published Rate for Medicare Part B deductible amount	Member pays \$0 of Medicare Published Rate for Medicare Part B deductible amount.
Emergency Room Services	Member pays \$50 copay	Member pays \$0 of Medicare allowable balance remaining after Medicare payment
Urgent Care	Member pays \$20 office visit copay	Member pays \$0 of Medicare allowable balance remaining after Medicare payment
Durable Medical Equipment	Member pays \$0 copay	Member pays \$0 of Medicare allowable balance remaining after Medicare payment
Prosthetic Devices	Member pays \$0	Member pays \$0
Skilled Nursing Facility	Member pays \$0 for first 100 days; beginning day 101 and beyond member pays 100%	Member pays \$0 for first 100 days; beginning day 101 and beyond member pays 100%

Table VII– Summary of Retiree Medical Benefits for Post Age-65 Retirees who retire on or after November 5, 2021 (continued)

Description	UnitedHealthcare – Plan N	UnitedHealthcare – Plan F
Home Health Care	For Medicare covered services, member pays \$0	For Medicare covered services, member pays \$0
Hearing Aids	Plan provides \$3,000 hearing aid allowance every 36 months, both ears combined. Member pays any balance in excess of the \$3,000 allowance every 36 months. Hearing exam \$0	Plan provides \$3,000 hearing aid allowance every 36 months, both ears combined. Member pays any balance in excess of the \$3,000 allowance every 36 months. Hearing exam \$0
Routine Eye Exam & Podiatry Exam	Member pays \$20 copay for Medicare covered eye and podiatry exam. Eyewear and podiatry member pays 100%.	Member pays \$0 copay for Medicare eye and podiatry exam. Eyewear and podiatry member pays 100%.
Oral Surgery & Dental Services	Medicare covered dental, member pays \$20 copay. Routine dental and oral surgery, member pays 100%.	Medicare covered dental, member pays \$0. Routine dental and oral surgery, member pays 100%.
Prescription Drugs	Retail: \$10 Tier 1 (most generics) \$15 Tier 2 \$25 Tier 3 and Tier 4 Mail Order: Two times the retail copay for 90-day supply	Retail: \$10 Tier 1 (most generics) \$15 Tier 2 \$25 Tier 3 and Tier 4 Mail Order: Two times the retail copay for 90-day supply
Inpatient Mental Health and Substance Abuse	Member pays \$0 for Medicare published rate for Medicare Part A deductible amount for first 60 days; member pays \$0 for Medicare-covered days 6- 150 + \$0 for Non-Medicare covered 365 Additional Lifetime Reserve days; beyond the Additional Lifetime Reserve days member would pay 100%.	Member pays \$0 for Medicare published rate for Medicare Part A deductible amount for first 60 days; member pays \$0 for Medicare-covered days 6- 150 + \$0 for Non-Medicare covered 365 Additional Lifetime Reserve days; beyond the Additional Lifetime Reserve days member would pay 100%.
Medicare Preventive Care Services	Member pays \$0	Member pays \$0
Acupuncture	Member pays \$15 per visit, up to 30 visits per year	Member pays \$15 per visit, up to 30 visits per year
Fitness Membership	Member pays \$0	Member pays \$0
Caregiver	Member pays \$0	Member pays \$0
Nurseline	Member pays \$0	Member pays \$0
Wellness Advising	Member pays \$0	Member pays \$0

Table VIII– Summary of Monthly Retiree Medical and Dental Benefit Cost Sharing for Pre Age-65 and Post Age-65 Retirees who retire on or after November 5, 2021

Health Plan	Company Contributions
<p>MEDICAL</p> <p><u>Pre-Age 65 Retirees:</u></p> <p>Anthem Blue Cross Select HMO</p> <p>Anthem Blue Cross California Care HMO</p> <p>Kaiser Permanente HMO</p> <p>Anthem Health Care Plus+</p> <p>Anthem Blue Cross Out-of-Area PPO</p>	<p>Retiree Only: 100% of the monthly premium or \$500, whichever is less.</p> <p>Retiree + 1 or More Dependents: 100% of the monthly premium or \$1,000, whichever is less.</p>
<p>MEDICAL</p> <p><u>Post-Age 65 Retirees:</u></p> <p>Kaiser Permanente Senior Advantage</p> <p>UnitedHealthcare Medicare Advantage</p> <p>UnitedHealthcare – Plan N</p> <p>UnitedHealthcare – Plan F</p>	<p>Retiree Only: 100% of the monthly premium or \$250, whichever is less.</p> <p>Dependent Spouse or Domestic Partner: 100% of the monthly premium or \$500, whichever is less.</p>
<p>DENTAL</p> <p><u>Pre-Age 65 and Post-Age 65 Retirees:</u></p> <p>Delta</p> <p>MetLife</p>	<p>Retiree Only: 100% of the monthly premium or \$24.50, whichever is less.</p> <p>Retiree + 1 or More Dependents: 100% of the monthly premium or \$45, whichever is less.</p>

ATTACHMENT A
Southern California Gas Company
Healthcare Reimbursement Account Plan
FOR REPRESENTED RETIREES

(Amended and Restated Effective as of January 1, 2012)

Purpose and Establishment

Southern California Gas Company originally established the Southern California Gas Company Healthcare Reimbursement Account Plan (the “HRAP”) as of the Effective Date.

The HRAP is designed to reimburse Qualifying Health Care Expenses of Covered Retirees and their Dependents. The HRAP is intended to qualify as a health plan under Code Section 105(e) and as a flexible spending arrangement as defined in Code Section 106(c)(2). Qualifying Health Care Expense reimbursements under the HRAP are intended to be excluded from the gross income of Covered Retirees pursuant to Code Section 105(b). The HRAP is paid for solely by the Company. The HRAP is a component plan of The Southern California Gas Company Represented Health and Welfare Plan, Plan No. 528. The Southern California Gas Company Voluntary Employees’ Beneficiary Association Represented Retiree Medical Trust, which is intended to qualify as a tax-exempt “voluntary employees’ beneficiary association” under Code Section 501(c)(9), will be the funding vehicle for the Plan.

ARTICLE I -- DEFINITIONS

Section 1.1 **Claim Administrator.** Claim Administrator means the person or entity, if any, to whom the Plan Administrator delegates claim administration responsibility pursuant to Section 6.5, including responsibility for:

- (a) receiving and reviewing claims for HRAP benefits;
- (b) determining benefit amounts payable;
- (c) disbursing benefit payments;
- (d) reviewing denied claims; and
- (e) determining appeals.

Section 1.2 **COBRA.** COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Section 1.3 **Code.** Code means the Internal Revenue Code of 1986, as amended.

Section 1.4 **Collective Bargaining Agreement.** Collective Bargaining Agreement means the agreement between The Southern California Gas Company, Utility Workers Union of America, AFL-CIO, and International Chemical Workers Union Council, UFCW, AFL-CIO, dated **November 5, 2021.**

Section 1.5 **Company.** Company means The Southern California Gas Company, a California corporation, and any successor by merger or otherwise. The Company is the plan sponsor.

Section 1.6 **Covered Retiree.** Covered Retiree means an Eligible Retiree who satisfies the requirements to receive a contribution to his or her Reimbursement Account under the terms of the HRAP contribution program described in Section 3.3.

Section 1.7 **Date of Retirement** means the first day of the month following the date on which an Eligible Retiree completes the Company's retirement process.

Section 1.8 **Dependent.** Dependent means the Covered Retiree's spouse, within the meaning of applicable federal law, on the Covered Retiree's last day of employment with the Company and a Covered Retiree's dependent (as defined in Code Section 152, determined without regard to Section 152(b)(1), (b)(2), and (d)(1)(B)).

Section 1.9 **Effective Date.** Effective Date means the original effective date of the HRAP, which is **March 1, 2009.**

Section 1.10 **Eligible Retiree.** Eligible Retiree means a Retiree (a) who was a former, active, full-time employee of the Company or a full-time employee of the Company receiving long-term disability benefits from a Company-sponsored plan, and (b) who was covered by a Collective Bargaining Agreement at the time he or she is determined by the Company to have retired.

Section 1.11 **ERISA.** ERISA means the **Employee** Retirement Income Security Act of 1974, as amended.

Section 1.12 **HRAP.** HRAP means the Southern California Gas Company Healthcare Reimbursement Account Plan, as amended from time to time.

Section 1.13 **Holiday Credits.** Holiday Credits means Holiday Credits as the term is defined in the Collective Bargaining Agreement.

Section 1.14 **Plan Administrator.** Plan Administrator means the Sempra Energy Benefits Committee.

Section 1.15 **Plan Year.** Plan Year means the 12-month period beginning January 1 and ending December 31. The first Plan Year shall be a short year commencing on the Effective Date and ending on December 31, 2009.

Section 1.16 **Qualifying Health Care Expenses.** Qualifying Health Care Expenses mean substantiated expenses incurred for "medical care" as defined in Code Section 213(d)(1)(A) and (B), premiums paid for health insurance coverage as provided under Code Section 213(d)(1)(D)

(other than premiums for any qualified long-term care insurance contracts), and expenses for medicines and drugs purchased without a prescription that are used for medical care. Qualifying Health Care Expenses generally include the expenses set forth from time to time by the Internal Revenue Service in Publication 502.

Section 1.17 **Reimbursement Account.** Reimbursement Account means the recordkeeping account established by the Plan Administrator for each Covered Retiree.

Section 1.18 **Retiree.** Retiree means an individual who has been determined by the Company to have terminated his or her employment through the Company's retirement process on or after December 1, 2009.

Section 1.19 **Sick Leave.** Sick Leave includes short-term annual accrued sickness allowance, extended-term paid sickness leave, and bonus sick leave allowance as these terms are defined in the Collective Bargaining Agreement.

Section 1.20 **Vacation.** Vacation includes vacation allowance and carryover vacation, as these terms are defined in the Collective Bargaining Agreement.

Section 1.21 **Years of Service.** Years of Service shall be calculated in accordance with the Collective Bargaining Agreement.

ARTICLE II -- COVERAGE

Section 2.1 **Commencement and Termination of Coverage.** An Eligible Retiree shall become, effective as of the Date of Retirement, a Covered Retiree under the HRAP on the date the Company makes a contribution to a Reimbursement Account established for the Eligible Retiree. Coverage under the HRAP will terminate when the balance of the Reimbursement Account is fully exhausted or, if earlier, upon the death of the Covered Retiree and all Dependents entitled to reimbursement from the Reimbursement Account. No benefits will be payable from the HRAP for Qualifying Health Care Expenses incurred after HRAP coverage terminates.

Section 2.2 **COBRA Coverage.** If a Dependent who qualifies as a "qualified beneficiary" (within the meaning of COBRA) has a COBRA qualifying event, the Dependent shall be offered COBRA continuation coverage under the HRAP, to the extent required by law.

ARTICLE III -- EMPLOYER CONTRIBUTIONS

Section 3.1 **Contributions Excludable from Gross Income.** From time to time, the Company will make contributions to the Reimbursement Account of an Eligible Retiree pursuant to the contribution program described in Section 3.3. The contribution program is not required to be funded or insured. The Company contributions to the Reimbursement Account (including contributions under Section 3.4) are intended to be excludable from the Covered Retiree's gross income under Code Section 106.

Section 3.2 **Compliance with Nondiscrimination Rules.** The contribution program under the HRAP shall satisfy the nondiscrimination requirements contained in Code Section 105(h). To the extent required to comply with the nondiscrimination requirements of Code Section

105(h), the Plan Administrator may take whatever action it deems in its sole discretion necessary, including, without limitation, imposing a maximum contribution amount on the Reimbursement Account contributions (including contributions under Section 3.4) of Eligible Retirees who the Plan Administrator determines constitute “highly compensated individuals” within the meaning of Code Section 105(h). For purposes of identifying such “highly compensated individuals,” an Eligible Retiree’s “compensation” shall be as determined under the Southern California Gas Company Pension Plan, to the extent not inconsistent with Code Section 105(h). Amounts in excess of the maximum contribution amount that are attributable to Vacation, Sick Leave and, with respect to an Eligible Retiree whose Date of Retirement is on or after July 1, 2012, Holiday Credits shall be paid by the Company to the Eligible Retiree as soon as practicable after the Plan Administrator determines that a maximum contribution limit must be imposed. Interest deemed credited to the Reimbursement Account that is attributable to the Vacation, Sick Leave and, with respect to an Eligible Retiree whose Date of Retirement is on or after July 1, 2012, Holiday Credits in excess of the maximum contribution limit shall be forfeited.

Section 3.3 Reimbursement Account Opening Balance. A Reimbursement Account shall be established for Eligible Retirees upon the Date of Retirement. Effective as of an Eligible Retiree’s Date of Retirement, the Company shall contribute, subject to Section 3.2, an amount equal to the following factors valued at the Eligible Retiree’s straight-time hourly wage rate on the Eligible Retiree’s last day as a represented, active full-time employee of the Company:

(a) The following percentage of the Eligible Retiree’s unused Sick Leave on the Date of Retirement if the Date of Retirement is on or after December 1, 2009 and before July 1, 2012:

- (i) For Eligible Retirees with 40 or more Years of Service as of January 1, 2009, 30% of unused Sick Leave;
- (ii) For Eligible Retirees with 30 or more Years of Service as of January 1, 2009 but less than 40 Years of Service, 25% of unused Sick Leave;
- (iii) For Eligible Retirees with 20 or more Years of Service as of January 1, 2009 but less than 30 Years of Service, 20% of unused Sick Leave;
- (iv) For Eligible Retirees with less than 20 Years of Service as of January 1, 2009, 10% of unused Sick Leave.

(b) The following percentage of the Eligible Retiree’s unused Sick Leave on the Date of Retirement if the Date of Retirement is on or after July 1, 2012:

- (i) For Eligible Retirees with 40 or more Years of Service as of January 1, 2009, 50% of unused Sick Leave;
- (ii) For Eligible Retirees with 30 or more Years of Service as of January 1, 2009 but less than 40 Years of Service, 45% of unused Sick Leave;

- (iii) For Eligible Retirees with 20 or more Years of Service as of January 1, 2009 but less than 30 Years of Service, 40% of unused Sick Leave;
 - (iv) For Eligible Retirees with less than 20 Years of Service as of January 1, 2009, 30% of unused Sick Leave.
- (c) All of the Eligible Retiree's unused Vacation on the Date of Retirement.
 - (d) All of the Eligible Retiree's unused Holiday Credits on the Date of Retirement if the Date of Retirement is on or after July 1, 2012.

Section 3.4 **Reimbursement Account Interest Credits.** Reimbursement Accounts shall be deemed to earn interest on a monthly basis based on one-twelfth (1/12th) of the 30-year Treasury bond rate average for the month of November of the year prior to the Plan Year in which the interest is credited. Interest will be deemed credited on the first day of the month based on the ending balance of the Reimbursement Account on the last day of the month immediately preceding the month in which the interest is deemed to have been credited.

ARTICLE IV -- HEALTH CARE REIMBURSEMENT BENEFITS

Section 4.1 **Reimbursements.** The Reimbursement Account of a Covered Retiree will be debited by the amount of any Qualifying Health Care Expenses reimbursed to a Covered Retiree from his or her Reimbursement Account. Any unused balance in a Covered Retiree's Reimbursement Account at the end of a Plan Year shall remain in the Reimbursement Account and be available for the reimbursement of Qualifying Health Care Expenses incurred in future years.

Section 4.2 **Timing and Reimbursement Limit of Qualifying Health Care Expenses.** Subject to the following terms and conditions, Covered Retirees are entitled to reimbursement for Qualifying Health Care Expenses that are incurred by the Covered Retiree or his or her Dependent after a Reimbursement Account has been established for the Covered Retiree. Incurred refers to the date the medical care is provided, not to the date the expense is charged, billed, or paid. Reimbursements of Qualifying Health Care Expenses may not exceed the amount in a Covered Retiree's Reimbursement Account at the time the Qualifying Health Care Expense is incurred or at the time the reimbursement is paid to a Covered Retiree.

Section 4.3 **No Double Recovery of Expenses.** The HRAP reimburses Qualifying Health Care Expenses only to the extent the expenses are not compensated for by any prepaid health coverage, group health plan, medical insurance, or otherwise. Qualifying Health Care Expenses include deductibles, co-payments, and penalties assessed for failure to pre-certify, as long as such expenses are not reimbursed from any other source.

Section 4.4 **Substantiation Requirement.** The HRAP reimburses Qualifying Health Care Expenses only to the extent the expenses are substantiated pursuant to procedures established by the Claim Administrator.

ARTICLE V -- CLAIM PROCEDURES

Section 5.1 **Automatic Claims Payment.** Subject to the provisions of Sections 4.3 and 4.4, claims for Qualifying Health Care Expenses processed under a component group health plan in the Southern California Gas Company Represented Health and Welfare Plan, Plan No. 528 and required to be paid by a Covered Retiree or Dependent may automatically be paid from the Covered Retiree's Reimbursement Account, as determined by the Plan Administrator in its sole discretion.

Section 5.2 **Filing a Claim.** Subject to the provisions of Sections 4.3 and 4.4, any claims for Qualifying Health Care Expenses that are not automatically paid from a Covered Retiree's Reimbursement Account must be submitted to the Claims Administrator. All claims should be mailed to the Claim Administrator's address listed on the claim form. The Claim Administrator must receive a claim within 90 days after the end of the year in which the claim was incurred. Claims will be processed in the order received by the Claim Administrator.

Section 5.3 **Claim Documentation.** Receipt of a claim by the Claim Administrator will be deemed written proof of loss and will serve as written authorization from the Covered Retiree to the Claim Administrator to obtain any medical or financial records and documents useful to the Claim Administrator. The Claim Administrator, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim is processed. Any party who submits medical or financial reports and documents to the Claim Administrator in support of a Covered Retiree's claim will be deemed to be acting as the agent of the Covered Retiree.

Section 5.4 **Claim Determination.** A determination on a claim will be sent within a reasonable time period, but no later than 30 days after receipt of the claim by the Claim Administrator.

Section 5.5 **Claim Processing Extension.** An extension of 15 days may be necessary if the Claim Administrator determines that, for reasons beyond the control of the Claim Administrator, an extension is necessary. If an extension is necessary, the Claim Administrator will notify the Covered Retiree within the initial 30 day time period that an extension is necessary, the circumstances requiring the extension, and the date the Claim Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Covered Retiree will have at least 45 days to provide the required information. If the Claim Administrator does not receive the required information within the 45-day time period, the claim will be denied. The Claim Administrator will make its determination within 15 days of receipt of the requested information, or, if earlier, the deadline to submit the information.

Section 5.6 **Appeal of Adverse Benefit Determination.** A Covered Retiree has 180 days from receipt of an adverse benefit determination to file an appeal. An appeal must be in writing, must state that a formal appeal is being requested and include all pertinent information regarding the claim in question, and must include the Covered Retiree's name, address, social security number, and any other information, documentation, or materials that support the Covered Retiree's appeal.

The Covered Retiree will have the opportunity to submit written comments, documents, or other information in support of the appeal, and will have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

If the appealed claim involves an exercise of medical judgment, the Claim Administrator will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

The Claim Administrator will decide the appeal within a reasonable period of time, but no later than 30 days after receipt of the appeal. If the Covered Retiree disagrees with the Claim Administrator's decision, the Covered Retiree can submit a second appeal within 90 days after receipt of the final decision of the first appeal. The Claim Administrator will decide the second appeal within a reasonable period of time, but no later than 30 days after receipt of the second appeal.

If a Covered Retiree's appeal is denied in whole or in part, the Covered Retiree will receive notice of an adverse benefit determination. The Covered Retiree will also receive a notice if the claim on appeal is approved.

Section 5.7 Delegation of Authority to Claim Administrator. The Plan Administrator has retained the Claim Administrator to assist the Plan Administrator in making the determination on appeal as the claims fiduciary. Accordingly, the Plan Administrator has delegated to the Claim Administrator complete discretionary authority to construe and interpret questions of entitlement to or eligibility for benefits under the terms of the HRAP. The Plan Administrator delegates to the Claim Administrator the complete discretionary authority to interpret and construe the HRAP as necessary to make determinations. It is understood and agreed that the Claim Administrator is a fiduciary with respect to its exercise of such discretionary authority. In making its decisions, the Claim Administrator will rely on the HRAP documents as approved by the Plan Administrator and will rely on eligibility data provided by the Plan Administrator. The Claim Administrator will undertake the responsibility for providing the initial and appellate review and final determination of claims that have been denied in whole or in part in accordance with the rules set forth in ERISA Section 503 and the regulations thereunder.

Section 5.8 Determination of Eligibility. If it is determined that a retiree is not eligible to participate in the HRAP or to receive a Company contribution under the contribution program described in Article III, the retiree may appeal that determination to the Plan Administrator. The Plan Administrator will make a determination on an eligibility appeal within a reasonable period of time but no later than 60 days after receipt of the eligibility appeal. The Plan Administrator shall notify the Retiree of the outcome of any eligibility appeal.

ARTICLE VI -- PLAN ADMINISTRATION

Section 6.1 Plan Administrator. The Sempra Energy Benefits Committee (the "Benefits Committee") shall be the Plan Administrator of the HRAP. No Benefits Committee member, including the chairman, may participate in a decision relating directly to his or her own benefits under the HRAP. The Benefits Committee may authorize one or more of its members to act on

behalf of the Benefits Committee with respect to time sensitive items requiring the Plan Administrator's approval.

Section 6.2 Duties of Plan Administrator. The Plan Administrator's duties include:

- (a) management of HRAP operations and administration according to the HRAP's terms and for the exclusive benefit of Covered Retirees and their Dependents;
- (b) maintenance of:
 - (i) records and data necessary or desirable for the HRAP's proper operation and administration;
 - (ii) governing documentation of the HRAP for inspection by any Eligible Retiree or Covered Retiree under the HRAP;
- (c) notification to Retirees eligible to participate in the HRAP of the HRAP's availability and terms; and
- (d) preparation and filing of all annual reports or returns, HRAP descriptions, and other documents required by law or under the HRAP's terms.

Section 6.3 Authority of Plan Administrator. Except for what the HRAP limits or reserves to the Pension and Benefits Committee of Sempra Energy or the Company, the Plan Administrator may exercise, in a uniform and nondiscriminatory manner sole and absolute discretion in the HRAP's operation and administration, including:

- (a) establishment of such rules and regulations as it deems necessary or proper for the efficient administration of the HRAP and for the payment of benefits under the HRAP;
- (b) interpretation of the HRAP, decisions regarding all questions of the eligibility of persons to participate in the HRAP, making factual determinations under the HRAP, construction of any ambiguous provision of the HRAP, correction of any defect, supplying any omission, or reconciliation of any inconsistency, in such manner and to such extent as the Plan Administrator in its discretion may determine; and any such action of the Plan Administrator will be binding and conclusive upon all Covered Retirees;
- (c) appointment of such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the HRAP, including, without limitation, Retirees; and
- (d) allocation and delegation of responsibilities under the HRAP and designation of such committees, entities, or persons including, without limitation, a third party administrator, to carry out any of its responsibilities under the HRAP. Any such allocation, delegation, or designation will be in writing, will be reviewed periodically by the Pension and Benefits Committee of Sempra Energy, and will be terminable upon such notice as the Pension and Benefits Committee in its discretion deems reasonable and proper under the circumstances.

Section 6.4 **Indemnification of Plan Administrator.** The Plan Administrator will use ordinary care and diligence in performing its duties. Unless the Company agrees otherwise, the Plan Administrator serves without compensation. However, the HRAP will pay all reasonable expenses the Plan Administrator incurs in performing its duties. The Company indemnifies and holds harmless any Retiree, officer, or director who serves or served as Plan Administrator from all claims, liability, and costs (including reasonable attorneys' fees) arising out of being the Plan Administrator or performing the Plan Administrator's duties, except if the claim, liability, or cost is the result of such individual's willful misconduct or bad faith.

Section 6.5 **Claim Administrator.** The Plan Administrator will appoint a Claim Administrator with the authority to determine all claims for benefits under the HRAP and to determine all appeals of disputed claims under the HRAP. The Claim Administrator will be a fiduciary under the HRAP with discretionary authority and discretionary responsibility for the administration of the HRAP.

ARTICLE VII -- HRAP AMENDMENT OR TERMINATION

Section 7.1 **Amendments.** The Pension and Benefits Committee of Sempra Energy (or its duly authorized representative) is granted the exclusive power and authority to amend the HRAP, including, without limitation, the authority to designate one or more self-insured health reimbursement plans within the HRAP in order to satisfy the nondiscrimination requirements of Code Section 105(h). Any action by the Pension and Benefits Committee of Sempra Energy under the HRAP including actions under this Article may be effected by resolution of the Pension and Benefits Committee of Sempra Energy or any duly authorized representative granted authority to take such action.

Section 7.2 **Right to Suspend or Terminate.** The Pension and Benefits Committee of Sempra Energy (or its duly authorized representative) reserves the right to suspend and/or terminate the HRAP, although such HRAP was established with the intention of being maintained indefinitely.

Section 7.3 **Effective Date of Amendment, Suspension or Termination.** An action of amendment, suspension, or termination will take effect on the date the Pension and Benefits Committee of Sempra Energy or its authorized representative indicates, except that no amendment, suspension, or termination may reduce HRAP benefits payable before the date of such amendment, suspension, or termination unless designed specifically to comply with a law or regulatory requirement authorizing such retroactive treatment.

ARTICLE VIII -- HIPAA PRIVACY AND SECURITY RULES – PROTECTED HEALTH INFORMATION

Section 8.1 The HRAP will comply with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") and Security Standards for the Protection of Electronic Protected Health Information (the "Security Rule"), promulgated pursuant to Title II of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), to the extent required by applicable law. The HIPAA requirements, if applicable, are set forth in the Company's summary plan descriptions for the group health plan benefits and are hereby incorporated into this HRAP.

ARTICLE IX -- MISCELLANEOUS PROVISIONS

Section 9.1 **No Right of Employment.** Nothing contained in the HRAP shall be construed as a contract of employment between the Company and any employee, as the right of any employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its employees with or without cause.

Section 9.2 **Anti-assignment Provision.** The Reimbursement Account and HRAP benefits are not subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge of any kind, and any attempt to affect any of these actions is void.

Section 9.3 **Forfeiture of Reimbursement Account Balance.** Upon the death of the **Covered** Retiree and all Dependents entitled to reimbursement from the Reimbursement Account, any balance remaining will be applied to any unreimbursed Qualifying Health Care Expenses incurred prior to the death of the Eligible Retiree or Dependent, as applicable, and any amounts remaining in the Reimbursement Account shall be forfeited. Neither the Eligible Retiree nor any other person has any right, currently or for any future year, to receive any benefit other than the reimbursement of Qualifying Health Care Expenses incurred by the **Covered** Retiree and Dependents.

Section 9.4 **Fraudulent Claim Repayment.** A Covered Retiree or Dependent who receives a HRAP benefit as a result of false or incomplete information or a misleading or fraudulent representation must repay all amounts the HRAP paid and will be liable for all collection costs including attorneys' fees and court costs.

Section 9.5 **Legal Action.** Before pursuing legal action, a person claiming HRAP benefits or seeking redress related to the HRAP must first exhaust all claim, review, and appeal procedures provided by the HRAP.

- (a) Unless otherwise required by law, the Plan Administrator is the only necessary parties to any action or proceeding that involves the HRAP or its administration.
- (b) No Retiree or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.
- (c) No action may be brought to recover HRAP benefits or seek redress related to the HRAP until 180 days after a properly completed claim form has been filed according to Article V. All legal actions with respect to HRAP benefits must be brought within 36 months after the date a covered expense was incurred.

Section 9.6 **Applicable Law.** The HRAP's provisions and all HRAP matters, including actions of the parties involved, will be construed and enforced according to applicable California laws unless they are preempted by Federal law.

Section 9.7 **Governing Plan Document.** This writing, together with the documentation incorporated by reference, is the legal instrument governing the HRAP.

Section 9.8 **Severability.** If an HRAP provision or its application is held invalid under governing law by a court of appropriate jurisdiction, the remainder of the HRAP and its application will remain in full force and effect.

Section 9.9 **Number and Gender.** Whenever any words are used herein in the masculine gender, they will be construed as though they were also used in the feminine gender in all cases where they would so apply. Whenever any words used herein are in the singular form, they will be construed as though they were also used in the plural form in all cases where they would so apply.

Section 9.10 **Limited Liability.** Neither the Company, the Pension and Benefits Committee of Sempra Energy or the Plan Administrator, nor any delegate thereof, shall be liable for:

- (a) good faith reliance on any fact or absence of fact, good faith action, or good faith omission;
- (b) any other action or omission, except for willful misconduct or willful breach of duty to the HRAP;
- (c) another person's act or omission, unless required by law; or
- (d) the tax consequences of contributions to or benefits paid from the HRAP.

This Section 9.10 shall not limit the liability of a third-party Claims Administrator that is unrelated to the Company nor affect any agreement by the Claims Administrator to indemnify the HRAP, Company, Pension and Benefits Committee or the Plan Administrator or any of their officers, members, directors, employees, participants or agents (other than the Claims Administrator).

**SOUTHERN CALIFORNIA GAS COMPANY
HEALTHCARE REIMBURSEMENT ACCOUNT PLAN
FOR REPRESENTED RETIREES
Amended and Restated Effective as of January 1, 2012
AMENDMENT NUMBER ONE**

Effective as of January 1, 2012, the Southern California Gas Company Healthcare Reimbursement Account Plan For Represented Retirees, Amended and Restated Effective as of January 1, 2012 (the "Plan"), is hereby further amended as follows:

1. Section 1.8 of the Plan is hereby amended in its entirety to read as follows:

"Section 1.8 **Dependent.** Dependent means the Covered Retiree's spouse, within the meaning of applicable federal law, on the Covered Retiree's last day of employment with the Company and a Covered Retiree's dependent (as defined in Code Section 152, determined without regard to Section 152(6)(1), (6)(2), and (d)(1)(B)). Dependent also shall mean a Covered Retiree's child (as defined in Code section 152(f)(1)) who has not attained age 26 as of the end of the taxable year."

2. Except as otherwise provided herein, all provisions of the Plan shall remain in effect.

**SOUTHERN CALIFORNIA GAS COMPANY
HEALTH CARE REIMBURSEMENT ACCOUNT PLAN FOR
REPRESENTED RETIREES
(Effective December 1, 2012)**

AMENDMENT NUMBER TWO

Effective as of January 1, 2014, the Southern California Gas Company Healthcare Reimbursement Account Plan for Represented Retirees (the "Plan") is hereby amended as follows:

1. The introduction to the Plan, entitled "Purpose and Establishment," is amended by the addition of a new sentence to the end to read as follows:

"The HRAP is intended to be a retiree-only plan that covers no active employees as current participants and which, thus, is exempt from the requirements of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively, "ACA")."

2. Amendment Number One to the Plan is superseded and Section 1.8 is amended to read as follows:

"1.8 Dependent. Dependent means the individual to whom a Covered Retiree is legally married on the Covered Retiree's last day of employment with the Company, and a Covered Retiree's dependent (as defined in Code Section 152, determined without regard to Section 152(b)(1), (b)(2), and (d)(1)(B)). Dependent shall also mean a Covered Retiree's child (as defined in Code section 152(±)(1)) who has not attained age 26 as of the end of the taxable year."

3. Article II is amended in its entirety to read as follows:

"ARTICLE II—COVERAGE

2.1 Commencement of Coverage. An Eligible Retiree shall become, effective as of the Date of Retirement, a Covered Retiree under the HRAP on the date the Company makes a contribution to a Reimbursement Account established for the Eligible Retiree.

2.2 Termination or Suspension of Coverage. Coverage under the HRAP will terminate when the balance of the Reimbursement Account is fully exhausted or, if earlier, upon the death of the Covered Retiree and all Dependents entitled to reimbursement from the Reimbursement Account. In addition, an Eligible Retiree will cease to be a Covered Retiree, and coverage for the Covered Retiree and his or her eligible Dependents will be suspended, upon the Covered Retiree's reemployment with, or other provision of services to, the Company or any Affiliated Employer (as defined in the Southern California Gas

Company Represented Retiree Group Health and Welfare Program) whether as a full-time, part-time, seasonal or contract employee, or pursuant to a leasing or similar arrangement. No benefits will be payable from the HRAP for Qualifying Health Care Expenses incurred after HRAP coverage terminates or is suspended, unless and until coverage is reinstated in accordance with Section 2.3.

2.3 Reinstatement of Coverage. If an Eligible Retiree's coverage is suspended due to reemployment as provided in Section 2.2, he or she shall again become a Covered Retiree and his or her coverage and coverage for his or her eligible Dependents will recommence upon a subsequent complete termination from employment.

2.4 **COBRA Coverage.** COBRA coverage will be provided in accordance with Article IX of the Southern California Gas Company Represented Retiree Group Health and Welfare Program."

4. Section 4.2 is amended by the addition to the end of a new sentence to read as follows:

"The HRAP will not reimburse any expenses incurred after coverage terminates or during a period in which coverage is suspended in accordance with Article II."

SOUTHERN CALIFORNIA GAS COMPANY HEALTH CARE REIMBURSEMENT ACCOUNT PLAN FOR REPRESENTED RETIREES

(Amended and Restated Effective December 1, 2012)

AMENDMENT NUMBER THREE

Effective as of December 5, 2016, the date this amendment is adopted, the Southern California Gas Company Healthcare Reimbursement Account Plan for Represented Retirees (the "Plan") is hereby amended as follows:

1. Section 1.8 of the Plan is amended in its entirety to read as follows:

"Section 1.8 **Dependent.** Dependent means the individual to whom the Covered Retiree is legally married, and a Covered Retiree's dependent (as defined in Code Section 152, determined without regard to Section 152(b)(1), (b)(2), and (d)(1)(B)). Dependent shall also mean a Covered Retiree's child (as defined in Code section 152(±)(1)) who has not attained age 26 as of the end of the taxable year."

2. Section 1.16 of the Plan is amended and clarified in its entirety to read as follows:

"Section 1.16 Qualifying Health Care Expenses. Qualifying Health Care Expenses mean substantiated expenses incurred for "medical care" as defined in Code Section

213(d)(1)(A) and (B), and premiums paid for health insurance coverage as provided under Code Section 213(d)(1)(D); provided, however, that Qualifying Health Care Expenses shall include expenses for a medicine or drug only if it is a prescribed drug or is insulin and shall not include the cost of long-term care services. Qualifying Health Care Expenses generally include the expenses set forth from time to time by the Internal Revenue Service in Publication 502 (other than the cost of long-term care services). Long-term care insurance premiums shall be Qualifying Health Care Expenses only up to the limits imposed under Code Section 213(d)(10)."

3. A new Section 4.5 is added to the Plan to read as follows:

"Section 4.5 **Debit Card**. If a Debit card is issued with respect to a Reimbursement Account, the requirements of this Section 4.5 shall apply with respect to the use of the Debit Card. For these purposes, "Debit Card" means a debit card, credit card, or stored-value card that can be used for the electronic reimbursement of Qualifying Health Care Expenses from a Covered Retiree's Reimbursement Account. A Debit Card may be used only for reimbursement of Qualifying Health Care Expenses incurred for services or supplies provided by (a) medical care providers and stores with merchant category codes that meet the requirements under applicable guidance issued by the Treasury Department or Internal Revenue Service, or (b) stores that meet the inventory information approval system requirements under applicable guidance issued by the Treasury Department or Internal Revenue Service.

- (a) A Debit Card shall be issued to each Covered Retiree with a Reimbursement Account who agrees to comply with all of the terms and conditions of use of the Debit Card. Without limitation, the Covered Retiree must certify in writing at the time of enrollment, and with each use of the Debit Card that he will use the card only for Qualifying Health Care Expenses; that the expense paid with the card has not been reimbursed; that he will not seek reimbursement from any other plan covering health benefits; and that he will acquire and retain sufficient documentation (including receipts and invoices) to substantiate the transaction. Use of the card in contravention of these terms may constitute fraud upon the HRAP and be treated accordingly by the HRAP Administrator. Payment of an expense with the Debit Card in accordance with the terms of this Section 4.5 shall be deemed to be, and shall be treated as, a reimbursement to Covered Retiree from his Reimbursement Account. Payment of an expense with the Debit Card shall be treated as conditional pending receipt of such substantiation documentation as the Claims Administrator may require; provided, these documentation requirements shall not apply in the following circumstances unless the Claims Administrator subsequently determines that payment was improper:

- (i) If the dollar amount of a transaction at a health care provider equals (1) the dollar amount, or (2) an exact multiple (not greater than 5) of that dollar amount, of the co-payment for that service or product under the Retiree Group Plan option elected by the Covered Retiree. If the Retiree Group Plan imposes multiple co-payments for the same benefit (such as tiered co-payments for

prescription drugs), this rule will be met if the dollar amount of a transaction is an exact match of multiples of combinations of up to five (5) co-payments.

(ii) If the claim is for reimbursement of a recurring Qualifying Health Care Expense that matches expenses previously approved as to amount, provider, and time period (for example, a claim by a Covered Retiree for a prescription drug that he has refilled on a regular basis at the same provider for the same amount).

(iii) If a merchant, health care provider or other independent third party (such as the Claims Administrator) provides information to verify that the claim is for a Qualifying Health Care Expense at the time and point of sale. If a merchant or health care provider complies with the inventory information approval system as required by applicable guidance issued by the Treasury Department or Internal Revenue Service.

(b) Notwithstanding the foregoing, the Debit Card may be used to purchase prescribed over-the-counter medicines or drugs only if the substantiation rules set forth in Notice 2011-5 or any successor guidance thereto are satisfied and if permitted by the Claims Administrator.

(c) In the event an expense paid with a Debit Card is determined not to be a Qualifying Health Care Expense, the Claims Administrator shall notify the Covered Retiree that he shall be required to repay the amount of such improper payment. Such notice shall comply with the procedures for denial of a claim under Article V. The Debit Card shall be deactivated and all unprocessed reimbursements under the Covered Retiree's Reimbursement Account may be suspended from the date of such notice until the date the Covered Retiree repays the amount or established that the payment was proper. If the Covered Retiree fails to repay the amount due or provide evidence that the payment was proper within sixty (60) days of the notice, the Claims Administrator shall offset, up to the amount of the improper payment, against any suspended claims reimbursement requests made by the Covered Retiree since the date of the Claims Administrator's notice of improper payment. If any amounts remain unpaid, the Claims Administrator shall (i) direct the Company to withhold from the Covered Retiree's compensation, if any, and remit to the Plan an amount sufficient to recover any remaining amounts due, but only to the extent permitted by applicable law and in accordance with the Company's payroll practices, and (ii) if any amounts still remain unpaid, offset such amounts against future claim reimbursement requests by the Covered Retiree. If the full amount of the improper payment is not recovered using these methods, then the HRAP shall treat the amount due as any other business indebtedness, and may treat the unrecovered amount as imputed income to the Covered Retiree. Any amounts which are recovered by the Claims Administrator shall be credited to the Covered Retiree's Reimbursement Account."

**UNIVERSAL AMENDMENT TO EACH HEALTHCARE REIMBURSEMENT
ACCOUNT PLAN TO REFLECT CARES ACT**

Effective as of January 1, 2020, the following plans:
Southern California Gas Company Healthcare Reimbursement Account Plan
(For Represented Retirees)

“Qualifying Health Care Expenses. Qualifying Health Care Expenses mean substantiated expenses incurred for "medical care" as defined in Code Section 213(d)(1)(A) and (B), and premiums paid for health insurance coverage as provided under Code Section 213(d)(1)(D); provided, however, that Qualifying Health Care Expenses shall also include menstrual care products as defined in Code 223(d)(2)(D) and shall not include the cost of long-term care services. Qualifying Health Care Expenses generally include the expenses set forth from time to time by the Internal Revenue Service in Publication 502 (other than the cost of long-term care services). Long-term care insurance premiums shall be Qualifying Health Care Expenses only up to the limits imposed under Code Section 213(d)(10).”