Duke Energy Kentucky, Inc.
Cash Account
Jan 2017 to July 2018

Account	Januray 1, 2017	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	July 2018
0131088 - Cash	$ 10,000.00	$ 12,250.00	$ 42,132.00	$ 15,695.59	$ 13,831.32	$ (4,323.00)	$ 20,165.87	$ 17,325.17	10,000.00	15,572.15	10,000.00	$ 30,666.34	$ 9,991.58	$ 14,491.58	$ 14,491.58	$ 15,114.90	$ 13,698.10	$ 10,000.00	$ 11,759.00	$ 10,375.00
0131100 - Cash - Various Banks	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0131147 - Cash	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0131155 - Cash	5,154,676.68	7,243,503.24	8,045,243.43	7,206,768.57	1,269,359.52	6,437,480.03	3,468,589.10	4,794,351.19	7,418,990.04	(269,217.20)	6,043,259.01	3,651,010.26	-	6,961,285.44	7,709,884.91	7,670,435.39	5,751,940.20	5,781,441.27	63,534.57	7,589,598.19
0131156 - Cash	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0131157 - Cash	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0131158 - Cash	428,002.52	664,498.90	831,196.86	454,866.33	474,997.30	629,248.30	366,350.23	490,734.70	379,634.80	355,733.33	488,345.41	287,900.22	432,949.66	518,408.17	498,928.93	498,928.93	-	-	-	-
0131159 - Cash	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0131160 - Cash	10,524.66	10,000.00	10,779.44	10,506.62	10,000.00	11,116.44	9,136.54	10,268.67	42,636.87	34,656.57	31,820.70	21,529.12	37,490.33	16,810.80	(59,288.82)	-	456,523.67	260,078.84	272,102.16	295,790.87
0131202 - Cash	930,631.85	969,007.33	676,768.56	483,335.38	864,671.91	985,806.98	596,841.70	566,408.06	533,967.67	788,508.56	731,002.92	342,724.11	1,206,714.28	755,827.11	1,173,383.89	25,000.00	460,014.48	1,224,243.83	922,326.13	1,012,247.66
0131210 - Cash Curr Asset HFS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash	$ 6,533,835.71	$ 8,899,259.47	$ 9,606,120.29	$ 8,171,172.49	$ 2,432,860.05	$ 8,059,328.75	$ 4,461,083.44	$ 5,879,087.79	$ 8,385,229.38	$ 925,253.31	$ 7,304,428.04	$ 4,533,830.05	$ 1,687,145.85	$ 8,266,823.10	$ 9,337,400.49	$ 8,209,479.22	$ 6,682,176.45	$ 7,275,763.94	$ 1,269,721.86	$ 8,908,001.72
0135000 - Cash - Working Funds	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
0135101 - Oth Dep - Petty Cash Fund	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Working Funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Cash	$ 6,533,835.71	$ 8,899,259.47	$ 9,606,120.29	$ 8,171,172.49	$ 2,432,860.05	$ 8,059,328.75	$ 4,461,083.44	$ 5,879,087.79	$ 8,385,229.38	$ 925,253.31	$ 7,304,428.04	$ 4,533,830.05	$ 1,687,145.85	$ 8,266,823.10	$ 9,337,400.49	$ 8,209,479.22	$ 6,682,176.45	$ 7,275,763.94	$ 1,269,721.86	$ 8,908,001.72

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-027

REQUEST:

Provide the average number of customers on Duke Kentucky's system (actual and projected), by rate schedule, for the base period and the three most recent calendar years.

RESPONSE:

See STAFF-DR-01-027 Attachment.

PERSON RESPONSIBLE: Bruce L. Sailers

STAFF-DR-01-027
EXCEL
ATTACHMENT

PROVIDED ON CD

Duke Energy Kentucky, Inc.
KYPSC Case No. 2018-00261
STAFF-DR 01-027
Average Monthly Customer Bills Annually 2015 - 2017 and Base Period
(Including Actual 6-month Base Period Separate from Forecast 6-month Base Period)

	Rate Schedules					
	RS	GS - Commercial	GS - Industrial	GS - OPA	FT-L	IT
2015	89,979	6,318	209	366	94	20
2016	90,749	6,372	205	366	97	22
2017	91,382	6,377	207	365	95	22
Base Period	91,843	6,490	207	366	94	22
Dec 2017 - May 2018	92,504	6,567	209	364	94	22
June 2018 - Nov 2018	91,183	6,413	206	368	94	22
Test Period	92,523	6,521	209	374	94	22

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-028

REQUEST:

Provide a schedule showing a comparison of the balance in the revenue accounts for each month of the most recent 12-month period for which information is available at the time Duke Kentucky files its application to the same month of the immediately preceding 12-month period for each revenue account or subaccount included in Duke Kentucky's chart of accounts. Include appropriate footnotes to show the month each rate change was approved and the month the full impact of the change was recorded in the accounts. See Schedule 28.

RESPONSE:

See STAFF-DR-01-028 Attachment.

PERSON RESPONSIBLE: Michael Covington

STAFF-DR-01-028
EXCEL
ATTACHMENT

PROVIDED ON CD

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
MONTHLY REVENUES AND EXPENSES BY ACCOUNT
PRIOR PERIOD

					3	4	5	6	7	8	9	10	11	12	13	14
Account	Description	CodePr	FERC	Total	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
403002	Depreciation Expense	DEPR	403	11,392,832	944,000	926,275	932,924	936,615	949,978	943,703	948,241	951,895	956,764	961,913	967,879	972,645
403150	Depreciation Expense - ARO	DEPR	403	0	0	0	0	0	0	0	0	0	0	0	0	0
404200	Amort Exp - Limited Term	DEPR	404	1,084,826	58,286	56,601	56,789	77,132	117,174	90,098	90,397	91,860	90,549	91,412	91,419	173,109
407355	DSM Amortization	OTH	407	901,105	(17,891)	(26,173)	15,939	143,072	433,374	435,096	299,522	216,028	(237,289)	(232,054)	(70,671)	(57,848)
408121	Taxes Property-Operating	OTHTX	408	3,545,151	307,167	307,167	307,167	721,368	308,477	227,803	227,667	227,667	227,667	227,667	227,667	227,667
408150	State Unemployment Tax	OTHTX	408	3,133	116	221	(817)	55	112	4,187	813	(1,806)	42	27	101	82
408151	Federal Unemployment Tax	OTHTX	408	2,171	51	78	25	31	51	1,488	(166)	(249)	320	323	394	(175)
408152	Employer FICA Tax	OTHTX	408	347,312	26,919	36,457	29,055	24,110	25,172	29,766	25,426	34,677	25,873	30,649	28,725	30,483
408205	Highway Use Tax	OTHTX	408	347	0	0	44	272	0	9	0	0	10	0	0	12
408470	Franchise Tax	OTHTX	408	15,073	0	0	0	3,933	8,437	0	0	1,158	0	772	387	386
408700	Fed Social Security Tax-Elec	OTHTX	408	1,000	0	(3,000)	1,000	1,000	5,000	0	0	(7,000)	0	0	4,000	0
408800	Federal Highway Use Tax - Gas	OTHTX	408	160	1	1	0	2	0	1	0	0	0	0	0	155
408851	Sales and Use Expense	OTHTX	408	(94)	0	(30)	0	1	1	0	0	0	(66)	0	0	0
408960	Allocated Payroll Taxes	OTHTX	408	233,781	22,297	20,989	13,653	23,009	53,616	64,364	29,270	(47,036)	19,121	15,673	14,883	3,942
409102	Sit Exp-Utility	FIT	409	1,319,901	(53,542)	690,876	21,017	87,377	261,167	0	687,447	(202,279)	0	(81,033)	(91,129)	0
409104	Current State Income Tax - PY	FIT	409	(1,198,974)	(1,008,457)	0	(190,517)	0	0	0	0	0	0	0	0	0
409190	Federal Income Tax-Electric-CY	FIT	409	6,715,968	(154,720)	4,713,458	90,316	672,995	1,516,498	0	3,573,224	(1,597,471)	0	(1,189,760)	(908,572)	0
409191	Fed Income Tax-Electric-PY	FIT	409	(6,390,376)	(6,390,376)	0	0	0	0	0	0	0	0	0	0	0
409195	UTP Tax Expense: Fed Util-PY	FIT	409	0	0	0	0	0	0	0	0	0	0	0	0	0
410100	DFIT: Utility: Current Year	FIT	410	6,111,426	656,674	(4,910,475)	793,104	515,986	426,218	0	1,307,130	4,711,096	0	1,776,642	835,051	0
410102	DSIT: Utility: Current Year	FIT	410	1,403,801	104,337	(787,298)	49,996	551,411	152,680	0	193,878	749,434	0	265,305	124,058	0
410105	DFIT: Utility: Prior Year	FIT	410	1,001,363	1,001,688	0	(325)	0	0	0	0	0	0	0	0	0
410106	DSIT: Utility: Prior Year	FIT	410	346,773	161,617	0	185,156	0	0	0	0	0	0	0	0	0
411050	Accretion Expense ARO	FIT	411	0	0	0	0	0	0	0	0	0	0	0	0	0
411100	DFIT: Utility: Curr Year CR	FIT	411	(9,248,298)	(456,652)	(69,240)	(888,325)	(1,255,101)	(747,256)	0	(2,561,999)	(2,501,136)	0	(558,315)	(210,274)	0
411101	DSIT: Utility: Curr Year CR	FIT	411	(1,756,884)	(107,282)	71,974	(165,452)	(101,689)	(200,989)	0	(517,541)	(455,632)	0	(194,258)	(86,015)	0
411102	DFIT: Utility: Prior Year CR	FIT	411	4,979,799	5,044,279	0	(64,480)	0	0	0	0	0	0	0	0	0
411103	DSIT: Utility: Prior Year CR	FIT	411	813,865	813,865	0	0	0	0	0	0	0	0	0	0	0
426510	Other	CO	426	478	0	446,017	16,442	(134,271)	(328,188)	0	0	0	0	0	0	478
426891	IC Sale of AR Fees VIE	CO	426	111,791	8,606	8,498	9,173	9,115	10,086	9,885	10,429	9,477	9,941	9,096	8,754	8,731
480000	Residential Sales-Gas	REV	480	60,995,920	2,209,946	2,285,251	2,400,394	3,613,804	8,483,213	12,121,117	8,828,699	7,836,503	4,984,546	3,398,120	2,502,566	2,331,761
480990	Gas Residential Sales-Unbilled	REV	480	37,184	8,505	53,256	489,483	1,763,936	2,740,272	(1,274,961)	(401,306)	(938,316)	(1,116,821)	(847,640)	(361,564)	(77,660)
481000	Industrial Sales-Gas	REV	481	1,504,542	34,444	35,817	41,455	75,210	223,741	357,952	239,643	231,722	135,456	60,187	36,231	32,684
481090	Gas Industrial Sales Unbilled	REV	481	2,598	6,211	1,896	14,648	41,373	(7,363)	(12,636)	(10,038)	(115)	(21,402)	(2,256)	(3,507)	(4,213)
481200	Gas Commercial Sales	REV	481	20,979,625	700,338	767,310	829,316	1,220,150	2,846,428	4,373,835	3,027,050	2,654,470	1,808,528	1,151,609	838,743	761,848
481290	Gas Commercial Sales Unbilled	REV	481	27,973	(114,341)	115,366	87,180	723,380	894,537	(639,671)	(87,549)	(211,281)	(470,567)	(182,113)	(156,323)	69,355
482000	Other Sales to Public Auth-Gas	REV	482	2,221,882	49,608	62,688	68,163	127,831	322,503	487,758	350,021	304,083	205,397	113,921	69,999	59,910
482090	Gas OPA Unbilled	REV	482	2,165	7,561	8,219	23,842	135,981	34,854	(24,923)	(3,882)	3,339	(142,446)	(15,999)	(22,565)	(1,816)
482200	Gas Public St Hwy Ltng	REV	482	976	77	81	83	79	84	84	79	83	80	82	84	80
484000	Interdepartmental Sales	REV	484	24,018	(60)	25	53	190	901	6,388	6,496	5,456	3,314	976	239	40
487001	Discounts Earn/Lost-Gas	REV	487	0	0	0	0	0	0	0	0	0	0	0	0	0
488000	Misc Service Revenue-Gas	REV	488	34,237	1,324	2,244	7,215	7,731	2,631	2,309	1,679	1,361	1,603	2,671	1,702	1,767
488100	IC Misc Svc Reg Gas Reg	REV	488	499,463	54,051	54,051	54,051	54,051	(74,168)	51,061	51,061	51,061	51,061	51,061	51,061	51,061
489000	Transp Gas of Others	REV	489	1,544,133	125,969	118,579	131,098	145,183	127,866	133,416	121,297	129,676	120,895	131,457	132,968	125,729
489010	IC Gas Transp Rev Reg	REV	489	522,072	43,506	43,506	43,506	43,506	43,506	43,506	43,506	43,506	43,506	43,506	43,506	43,506
489020	Comm Gas Transp Only	REV	489	998,522	53,419	56,062	69,723	88,926	141,187	143,569	108,794	115,170	68,010	57,124	50,821	45,717
489025	Comm Gas Transp Unbilled	REV	489	2,195	(6,339)	5,612	5,280	40,907	35,666	(25,436)	(9,165)	(6,124)	(26,006)	(8,366)	(8,007)	4,173
489030	Indust Gas Transp Only	REV	489	2,824,357	202,765	195,359	212,187	245,074	310,536	310,363	258,924	283,595	211,193	214,632	200,219	179,510
489035	Indust Gas Transp Unbilled	REV	489	5,395	9,003	2,022	35,273	97,942	(36,957)	(10,938)	(40,198)	15,403	(55,966)	(424)	(4,685)	(5,080)
489040	OPA Gas Transp Only	REV	489	332,090	9,358	10,085	15,646	33,540	63,182	56,374	42,123	43,864	20,261	17,821	10,057	9,779
489045	OPA Gas Transp Unbilled	REV	489	(114)	1,019	1,225	4,165	23,285	1,679	(1,050)	(5,831)	1,666	(20,944)	(2,273)	(2,910)	(145)
489200	Transportation Fees	REV	489	0	0	0	0	0	0	0	0	0	0	0	0	0
495031	Gas Losses Damaged Lines	REV	495	751	68	82	29	14	0	218	0	365	0	(25)	0	0
496020	Provision for Rate Refund	REV	496	0	0	0	0	0	0	0	0	0	0	0	0	0
711000	Gas Boiler Labor	PO	711	5,799	105	0	2	34	473	1,894	2,066	0	959	177	84	5
712000	Gas Production-Other Power Ex	PO	712	7,425	324	24	116	363	358	2,144	3,112	10,927	(10,067)	0	17	107

717000	Liq Petro Gas Exp-Vapor Proc	PO	717	94,182	2,077	8,606	7,540	20,449	13,130	6,218	9,476	12,812	5,128	2,130	3,784	2,832
728000	Liquid Petroleum Gas	PO	728	371,014	0	0	0	0	164,510	206,504	0	0	0	0	0	0
735000	Gas Misc Production Exp	PO	735	37,450	6,843	1,216	3,275	(2,082)	3,197	12,125	1,185	2,081	2,926	2,322	2,330	2,032
742000	Maint Gas Production Equipmen	PM	742	46,015	310	79	648	17,321	10,092	12,155	2,258	1,421	811	1,722	(923)	121
801000	Purchases Gas & NGL	Fuel	801	32,875,275	837,031	844,950	1,377,320	2,984,586	6,821,691	6,955,658	4,305,631	4,116,570	1,311,519	1,279,714	972,156	1,068,449
801001	Purchases Gas & NGL-Aff	Fuel	801	1,204,951	8,994	9,680	4,489	37,321	52,123	50,927	205,059	203,337	158,594	158,193	158,035	158,199
805002	Unrecovered Purchase Gas Adj	Fuel	805	2,570,402	(191,682)	(74,632)	(486,759)	(1,203,637)	(1,526,621)	2,002,075	1,515,541	1,013,072	1,702,066	317,383	(56,274)	(440,130)
805003	Purchase Gas Cost Unbilled Rev	Fuel	805	41,707	(43,142)	118,951	324,253	1,458,201	2,309,471	(1,356,963)	(199,218)	(613,133)	(960,611)	(651,938)	(333,934)	(10,230)
807000	Gas Purchased Expenses	PO	807	366,627	32,803	22,230	27,433	34,931	16,858	43,771	33,127	21,000	33,147	38,480	33,912	28,935
807100	I/C Gas Purchased Expenses	PO	807	40,769	823	992	2,270	304	3,288	4,818	6,999	8,172	6,303	4,054	2,242	504
813001	Other Gas Supply Expenses	PO	813	554,832	37,572	43,313	39,930	51,642	44,753	37,798	46,211	52,506	71,993	68,018	31,627	29,469
850001	Operation Supv & Eng-Tran	TO	850	0	0	0	0	0	0	0	0	0	0	0	0	0
870000	Distribution Sys Ops-Supv/Eng	DO	870	(1,603)	1,346	(797)	(2,152)	0	0	0	0	0	0	0	0	0
871000	Distribution Load Dispatching	DO	871	169,879	15,783	14,466	13,371	16,126	15,826	14,091	14,142	14,382	14,623	12,673	13,008	11,388
874000	Mains And Services	DO	874	3,264,799	251,591	431,389	237,942	237,898	135,821	227,549	211,099	235,086	148,015	159,731	311,759	676,919
875000	Measuring And Reg Stations-Ge	DO	875	67,229	11	17	987	3,250	62,027	10	18	11	861	10	10	17
876000	Measuring & Reg Station-Indus	DO	876	42,630	10,413	6,170	4,244	3,541	2,689	2,084	1,704	1,931	911	5,102	1,526	2,315
878000	Meter And House Regulator Exp	DO	878	2,048,725	138,763	145,682	200,381	53,928	162,636	201,470	79,521	248,516	35,972	496,530	76,061	209,265
879000	Customer Installation Expense	DO	879	1,662,725	226,181	266,604	35,479	73,182	224,818	191,128	138,796	163,683	80,565	80,899	76,778	104,612
880000	Gas Distribution-Other Expense	DO	880	2,577,399	217,448	237,465	223,979	187,349	282,518	205,231	176,038	188,008	74,086	433,663	234,930	116,684
885000	Maint Dist Sys Fac- Supv/Engr	DM	885	(2,992)	2,019	(1,192)	(3,819)	0	0	0	0	0	0	0	0	0
887000	Maintenance of Mains	DM	887	933,317	67,146	95,200	78,954	113,655	118,333	69,960	70,493	87,809	38,778	79,217	67,941	45,831
889000	Maint-Meas/Reg Stn Equip-Gas	DM	889	43,950	912	2,262	6,218	6,451	2,528	2,343	4,443	3,471	3,338	5,680	2,345	3,959
892000	Maintenance of Services	DM	892	693,462	90,539	27,679	48,169	11,794	60,701	29,703	22,602	207,194	21,937	106,467	18,579	48,098
893000	Maint - Meters And House Reg	DM	893	393,430	25,720	57,101	25,153	43,484	82,100	20,325	17,353	30,316	26,430	26,033	22,145	17,270
894000	Maint-Other Distribution Equip	DM	894	(9,237)	(32,462)	3,697	8,470	1,785	5,928	(8,357)	8,766	(7,078)	(525)	(1,814)	6,588	5,765
901000	Supervision-Cust Accts	CO	901	543,398	29,465	41,990	32,971	41,818	45,963	48,743	43,614	57,932	50,875	33,837	71,498	44,692
902000	Meter Reading Expense	CO	902	519,154	50,603	62,844	40,489	34,914	37,367	45,155	35,979	69,753	39,491	35,850	42,415	24,294
903000	Cust Records & Collection Exp	CO	903	1,696,383	173,653	160,463	174,155	152,661	61,699	162,718	136,539	164,458	103,986	159,940	129,266	116,845
903100	Cust Contracts & Orders-Local	CO	903	174,315	10,606	39,751	7,882	11,209	18,741	28,864	4,540	13,543	9,271	11,205	12,806	5,897
903200	Cust Billing & Acct	CO	903	967,724	47,340	167,830	133,003	137,477	49,834	45,550	133,051	59,103	49,693	48,606	51,808	44,429
903250	Cust Billing - Common	CO	903	0	0	(278,076)	80,681	150,444	46,951	0	0	0	0	0	0	0
903300	Cust Collecting-Local	CO	903	147,960	10,091	33,648	9,834	9,675	11,358	9,215	10,888	12,642	9,543	11,275	10,802	8,989
903400	Cust Receiv & Collect Exp-Edp	CO	903	26,484	1,236	1,514	1,924	2,037	3,999	2,186	1,956	2,102	2,175	2,335	3,006	2,014
903891	IC Collection Agent Revenue	CO	903	(76,313)	0	0	0	0	(52,261)	(4,350)	(3,705)	(3,508)	(2,856)	(2,834)	(3,170)	(3,629)
904001	BAD DEBT EXPENSE	CO	904	181,827	0	279,226	(80,913)	11,165	(36,108)	6,047	(7,828)	6,693	(205)	(121)	(34)	3,905
904003	Cust Acctg-Loss On Sale-A/R	CO	904	(407,539)	21,769	(429,308)	0	0	0	0	0	0	0	0	0	0
904891	IC Loss on Sale of AR VIE	CO	904	272,498	(2,616)	(2,962)	(3,135)	(11,165)	292,376	0	0	0	0	0	0	0
905000	Misc Customer Accts Expenses	CO	905	423	40	45	69	0	44	22	14	10	87	34	15	43
908000	Cust Asst Exp-Conservation Pro	CSI	908	1	0	0	0	0	1	0	0	0	0	0	0	0
908150	Commer/Indust Assistance Exp	CSI	908	0	0	0	0	0	0	0	0	0	0	0	0	0
908160	Cust Assist Exp-General	CSI	908	154,042	13,744	13,353	13,284	14,409	12,549	12,570	12,823	12,328	13,670	13,300	13,448	8,564
909650	Misc Advertising Expenses	CSI	909	745	336	0	0	64	133	0	0	211	0	0	0	1
910000	Misc Cust Serv/Inform Exp	CSI	910	189,745	14,798	16,558	15,665	16,381	19,139	20,123	27,430	10,457	8,913	22,432	2,482	15,367
910100	Exp-Rs Reg Prod/Svces-CstAccts	CSI	910	138,181	26,760	17,641	6,977	19,442	2,495	2,616	23,564	17,929	7,070	4,527	8,477	683
911000	Supervision	CSI	911	0	0	0	0	0	0	0	0	0	0	0	0	0
912000	Demonstrating & Selling Exp	SE	912	95,789	6,014	3,927	4,997	22,108	11,467	11,238	7,809	8,733	9,538	(4,223)	6,864	7,317
913001	Advertising Expense	SE	913	4,025	(1)	2	4	2,492	287	156	0	170	128	215	113	459
920000	A & G Salaries	AGO	920	1,867,919	122,412	122,160	125,926	128,274	384,158	114,969	121,493	65,228	180,138	159,516	201,994	141,651
921100	Employee Expenses	AGO	921	102,738	3,434	13,058	20,978	(3,901)	(2,468)	16,191	12,004	10,603	11,658	6,620	4,885	9,676
921101	Employee Exp - NC	AGO	921	0	0	0	0	0	0	0	0	0	0	0	0	0
921110	Relocation Expenses	AGO	921	2,141	841	199	46	10	352	320	13	220	0	0	140	0
921200	Office Expenses	AGO	921	178,754	15,269	13,130	9,737	12,316	17,743	10,159	17,197	8,614	15,596	20,067	23,810	15,116
921300	Telephone And Telegraph Exp	AGO	921	78	3	7	3	8	7	1	4	21	12	9	3	0
921400	Computer Services Expenses	AGO	921	198,675	18,897	12,907	18,936	15,095	21,491	17,655	25,729	20,632	5,711	6,582	7,748	27,292
921540	Computer Rent (Go Only)	AGO	921	102,149	5,768	22,043	7,093	6,691	6,045	6,061	6,404	6,252	5,985	7,497	11,713	10,597
921600	Other	AGO	921	494	39	127	44	52	52	10	10	14	54	75	13	4
921980	Office Supplies & Expenses	AGO	921	361,335	33,677	28,761	33,597	30,043	38,076	27,315	27,969	30,460	27,981	27,768	28,891	26,797
922000	Admin Exp Transfer	AGO	922	517	473	0	1	0	0	43	0	0	0	0	0	0
923000	Outside Services Employed	AGO	923	726,013	39,266	(37,854)	44,754	46,366	102,870	27,823	55,435	82,941	80,757	91,025	96,798	95,832
923980	Outside Services Employee &	AGO	923	(20,182)	(2,345)	(912)	(3,755)	(1,993)	(384)	(1,067)	(887)	(2,796)	(1,526)	(2,918)	299	(1,898)
924000	Property Insurance	AGO	924	1,224	138	(93)	138	200	(163)	137	123	(21)	137	(79)	(82)	789
924050	Inter-Co Prop Ins Exp	AGO	924	70,199	5,672	5,672	5,672	5,672	5,672	5,977	5,977	5,977	5,977	5,977	5,977	5,977
924980	Property Insurance For Corp.	AGO	924	57,040	4,961	4,961	4,961	4,961	4,961	4,605	4,605	4,605	4,605	4,605	4,605	4,605
925000	Injuries & Damages	AGO	925	112,922	2,914	4,149	3,423	3,405	4,839	7,631	5,065	6,684	7,941	5,887	55,994	4,990
925051	INTER-CO GEN LIAB EXP	AGO	925	261,400	20,325	20,325	20,325	20,325	20,325	22,825	22,825	22,825	22,825	22,825	22,825	22,825

925200	Injuries And Damages-Other	AGO	925	3,032	313	309	320	303	314	205	197	225	213	220	205	208
925300	Environmental Inj & Damages	AGO	925	147,702	0	144,493	0	0	2,469	0	0	301	0	0	439	0
925980	Injuries And Damages For Corp.	AGO	925	4,386	376	376	376	376	376	358	358	358	358	358	358	358
926000	EMPL PENSIONS AND BENEFITS	AGO	926	1,070,852	79,692	107,695	96,733	100,681	(24,705)	98,225	116,884	190,611	(13,792)	105,684	238,314	(25,170)
926430	Employees'Recreation Expense	AGO	926	26	0	0	0	1	14	0	0	0	0	0	0	11
926600	Employee Benefits-Transferred	AGO	926	588,392	61,142	55,392	45,679	82,828	36,596	91,653	65,989	16,042	42,651	19,054	72,638	(1,272)
926999	Non Serv Pension (ASU 2017-07)	AGO	926	0	0	0	0	0	0	0	0	0	0	0	0	0
928000	Regulatory Expenses (Go)	AGO	928	16	0	0	16	0	0	0	0	0	0	0	0	0
928006	State Reg Comm Proceeding	AGO	928	201,316	16,895	16,895	16,895	16,895	16,895	16,895	16,895	16,895	16,895	16,895	16,895	15,471
929000	Duplicate Chrgs-Enrgy To Exp	AGO	929	(37,984)	(289)	(65)	(66)	(224)	(1,338)	(10,878)	(12,250)	(4,701)	(5,925)	(1,592)	(563)	(93)
929500	Admin Exp Transf	AGO	929	(240,920)	(15,484)	(26,415)	(22,742)	(41,137)	(23,375)	(11,484)	(14,181)	(13,067)	(10,161)	(28,248)	(15,135)	(19,491)
930150	Miscellaneous Advertising Exp	AGO	930	7,279	348	836	542	545	525	578	627	369	737	1,351	125	696
930200	Misc General Expenses	AGO	930	220,475	5,533	124,464	(82)	10,145	13,566	54	(858)	63,075	(557)	657	3,613	865
930210	Industry Association Dues	AGO	930	22,079	96	0	0	0	0	25,917	0	(3,934)	0	0	0	0
930220	Exp Of Servicing Securities	AGO	930	(212)	(42)	148	(189)	(15)	(14)	0	0	13	0	2	(116)	1
930230	Dues To Various Organizations	AGO	930	18,634	0	2,340	3,189	5,058	6,125	256	21	291	1,070	12	272	0
930240	Director'S Expenses	AGO	930	18,399	277	266	1,918	110	2,383	2,435	4	167	1,758	7,695	32	1,354
930250	Buy\Sell Transf Employee Homes	AGO	930	8,911	325	1,903	379	364	826	757	31	1,153	239	248	833	1,853
930700	Research & Development	AGO	930	1,437	250	45	154	516	175	12	46	24	54	87	40	34
930940	General Expenses	AGO	930	586	75	38	21	9	73	38	173	11	60	29	11	48
931001	Rents-A&G	AGO	931	204,520	25,392	27,335	18,777	17,560	41,053	18,415	17,394	7,643	6,491	8,957	6,867	8,636
931008	A&G Rents-IC	AGO	931	289,340	21,697	21,533	21,847	21,853	25,271	28,648	28,466	31,244	31,007	19,169	19,063	19,542
932000	Maintenance Of Gen Plant-Gas	AGO	932	5,248	0	1,774	0	0	2,923	0	0	587	0	0	(36)	0
935100	Maint General Plant-Elec	AGM	935	(1,884)	83	(1,771)	528	1,570	(2,097)	(114)	(71)	185	752	139	(890)	(198)
935200	Cust Infor & Computer Control	AGM	935	710	73	(21)	414	98	119	72	(11)	(126)	5	18	54	15
				175,582,173	6,937,217	8,376,940	8,837,042	16,010,583	29,442,938	27,752,946	24,461,917	19,750,445	10,401,474	8,775,145	7,118,446	7,717,080
	Revenues	REV		92,559,984	3,396,432	3,818,736	4,532,790	8,482,093	16,154,298	16,098,335	12,521,403	10,565,487	5,799,698	4,184,071	3,378,635	3,628,006
	OperatingExpenses															
	Gas Purchased Expense	Fuel		36,692,335	611,201	898,949	1,219,303	3,276,471	7,656,664	7,651,697	5,827,013	4,719,846	2,211,568	1,103,352	739,983	776,288
	Operation															
	Production	PO		1,478,098	80,547	76,381	80,566	105,641	246,567	315,272	102,176	107,498	110,389	115,181	73,996	63,884
	Customer Accounts	CO		4,158,583	350,793	531,480	422,575	415,079	161,861	354,035	365,477	392,205	272,001	309,223	327,166	256,688
	Customer Service & Information	CSI		482,714	55,638	47,552	35,926	50,296	34,317	35,309	63,817	40,925	29,653	40,259	24,407	24,615
	Sales Expense	SE		99,814	6,013	3,929	5,001	24,600	11,754	11,394	7,809	8,903	9,666	(4,008)	6,977	7,776
	Transmission	TO		0	0	0	0	0	0	0	0	0	0	0	0	0
	Distribution	DO		9,831,783	861,536	1,100,996	714,231	575,274	886,335	841,563	621,318	851,617	355,033	1,188,608	714,072	1,121,200
	A&G	AGO		6,556,930	468,340	688,002	475,646	483,392	703,728	522,739	523,762	569,566	438,949	506,034	809,468	367,304
	Other	OTH		901,105	(17,891)	(26,173)	15,939	143,072	433,374	435,096	299,522	216,028	(237,289)	(232,054)	(70,671)	(57,848)
	Maintenance															
	Production	PM		46,015	310	79	648	17,321	10,092	12,155	2,258	1,421	811	1,722	(923)	121
	Transmission	TM		0	0	0	0	0	0	0	0	0	0	0	0	0
	Distribution	DM		2,051,930	153,874	184,747	163,145	177,169	269,590	113,974	123,657	321,712	89,958	215,583	117,598	120,923
	A&G	AGM		(1,174)	156	(1,792)	942	1,668	(1,978)	(42)	(82)	59	757	157	(836)	(183)
	Operation & Maintenance Expense			25,605,798	1,959,316	2,605,201	1,914,619	1,993,512	2,755,640	2,641,495	2,109,714	2,509,934	1,069,928	2,140,705	2,001,254	1,904,480
	Total Operating Expense			62,298,133	2,570,517	3,504,150	3,133,922	5,269,983	10,412,304	10,293,192	7,936,727	7,229,780	3,281,496	3,244,057	2,741,237	2,680,768
	Depreciation Expense	DEPR		12,477,658	1,002,286	982,876	989,713	1,013,747	1,067,152	1,033,801	1,038,638	1,043,755	1,047,313	1,053,325	1,059,298	1,145,754
	Amortization of Deferred Expenses															
	Taxes Other Than Income Taxes	OTHTX		4,148,034	356,551	361,883	350,127	773,781	400,866	327,618	283,010	207,411	272,967	275,111	276,157	262,552
	Income Taxes	FIT		4,098,364	(388,569)	(290,705)	(169,510)	470,979	1,408,318	0	2,682,139	704,012	0	18,581	(336,881)	0
	Operating Income			9,537,795	(144,353)	(739,468)	228,538	953,603	2,865,658	4,443,724	580,889	1,380,529	1,197,922	(407,003)	(361,176)	(461,068)
	Operating Income - Before Income Taxes			13,636,159	(532,922)	(1,030,173)	59,028	1,424,582	4,273,976	4,443,724	3,263,028	2,084,541	1,197,922	(388,422)	(698,057)	(461,068)
	Total Expense			83,022,189	3,540,785	4,558,204	4,304,252	7,528,490	13,288,640	11,654,611	11,940,514	9,184,958	4,601,776	4,591,074	3,739,811	4,089,074
	Per HFM Financials															
	Revenues - Total				3,421,101	3,851,547	4,534,241	8,356,430	15,738,421	15,669,293	12,239,046	10,469,416	6,043,276	4,422,523	3,331,602	3,692,001
	OperatingExpenses															
	Gas Purchased Expense				611,200	898,949	1,219,302	3,276,471	7,656,665	7,651,696	5,827,013	4,719,846	2,211,569	1,103,352	739,983	776,289
	Other O&M				2,003,711	2,572,090	1,928,023	1,892,147	2,457,219	2,276,130	1,865,410	2,341,356	1,361,122	2,452,961	2,093,506	2,009,034
	Depreciation Expense				1,002,287	982,876	989,713	1,013,747	1,067,152	1,033,802	1,038,638	1,043,754	1,047,313	1,053,325	1,059,298	1,145,754
	Amortization of Deferred Expenses															
	Taxes Other Than Income Taxes				359,020	364,352	352,621	776,249	400,569	329,912	285,304	209,706	275,263	277,406	278,449	264,848
	Total Operating Expense				3,976,218	4,818,267	4,489,659	6,958,614	11,581,605	11,291,540	9,016,365	8,314,662	4,895,267	4,887,044	4,171,236	4,195,925

Operating Income			(555,117)	(966,720)	44,582	1,397,816	4,156,816	4,377,753	3,222,681	2,154,754	1,148,009	(464,521)	(839,634)	(503,924)
Variance:		**Accounts**												
Revenues	REV	407354, 415530, 417007, 5550	24,669	32,811	1,451	(125,663)	(415,877)	(429,042)	(282,357)	(96,071)	243,578	238,452	(47,033)	63,995
OperatingExpenses														
Gas Purchased Expense	Fuel		(1)	0	(1)	0	1	(1)	0	0	1	0	0	1
Other O&M			44,395	(33,111)	13,404	(101,365)	(298,421)	(365,365)	(244,304)	(168,578)	291,194	312,256	92,252	104,554
Depreciation Expense	DEPR		1	0	0	0	0	1	0	(1)	0	0	0	0
Amortization of Deferred Expenses			0	0	0	0	0	0	0	0	0	0	0	0
Taxes Other Than Income Taxes	OTHTX		2,469	2,469	2,494	2,468	(297)	2,294	2,294	2,295	2,296	2,295	2,292	2,296
Total Operating Expense			46,864	(30,642)	15,897	(98,897)	(298,717)	(363,071)	(242,010)	(166,284)	293,491	314,551	94,544	106,851
Operating Income			(22,195)	63,453	(14,446)	(26,766)	(117,160)	(65,971)	(40,347)	70,213	(49,913)	(76,099)	(141,577)	(42,856)
Explanation:														
Revenue														
407355 DSM Deferral - gas (in model as expense)			17,891	26,173	(15,939)	(143,072)	(433,374)	(435,096)	(299,522)	(216,028)	237,289	232,054	70,671	57,848
415100 Other Misc Gas Revenue			0	0	0	0	50	0	0	0	0	50	0	0
415530 Marketing Service Revenue			0	0	10,926	10,915	10,937	(358)	10,774	113,526	0	0	0	0
417000 Misc Revenue			0	0	0	0	0	0	0	0	0	0	0	0
417310 Products & Services - NonReg			6,728	6,590	6,414	6,446	6,461	6,351	6,336	6,336	6,288	6,297	6,183	6,090
454400 Other Electric Rents			18	18	18	18	18	32	26	66	(30)	20	23	23
417007 Misc Rev Reg			31	30	33	30	31	30	29	30	30	30	33	33
442100 General Services			0	0	0	0	0	0	0	0	0	0	0	0
Rounding			1	-	(1)	-	-	(1)	-	(1)	1	1	-	1
Total Revenue Variance			24,669	32,811	1,451	(125,663)	(415,877)	(429,042)	(282,357)	(96,071)	243,578	238,452	76,910	63,995
			0	0	0	0	0	0	0	0	0	0	(123,943)	0
Purchased Gas Expense														
800101 Gas Purchase Estimate			0	0	0	0	0	0	0	0	0	0	0	0
Rounding			(1)	-	(1)	-	1	(1)	-	-	1	-	-	1
Total Fuel Expense Variance			(1)	0	(1)	0	1	(1)	0	0	1	0	0	1
			0	0	0	0	0	0	0	0	0	0	0	0
Other O&M														
401100 Non-reg Operations			0	0	0	0	0	0	0	0	0	0	0	0
407355 DSM Deferral - gas (in model as expense)			17,891	26,173	(15,939)	(143,072)	(433,374)	(435,096)	(299,522)	(216,028)	237,289	232,054	70,671	57,848
411050 Accretion Expense - ARO			0	0	0	0	0	0	0	0	0	0	0	0
426100 Donations			2,206	12,599	14,968	23,953	32,321	1,611	7,808	10,391	14,413	31,138	18,789	(12,151)
426512 Donations			652	847	837	922	1,597	14,577	1,459	1,235	1,152	785	1,009	914
416330 Miscellaneous Exp			0	0	(177)	1,185	(229)	(490)	(182)	0	0	0	0	0
417320 Exp Non Reg Products & Services			0	7	68	0	1	0	0	16	8	0	1	0
417550 Misc. Operating Fee			0	0	0	0	0	0	0	0	0	0	0	0
426300 Penalties			0	0	0	0	0	0	0	0	0	0	0	0
426400 Exp/ Civic & Political Activity			5,228	31,132	8,301	9,861	11,834	26,578	22,559	33,663	14,155	16,096	15,888	18,857
426509 Loss on Sale of AR			0	0	0	0	388,257	96,204	115,812	44,922	63,369	29,952	21,432	45,268
426510 Other			0	0	0	0	0	0	0	0	0	0	0	0
426521 Sale of AR Fees			0	0	0	0	0	0	0	0	0	0	0	0
426540 Employee Service Club Dues			353	661	103	447	515	208	67	324	66	66	0	0
426591 I/C - Loss on Sale of AR			0	0	0	0	(288,760)	(73,902)	(98,821)	(31,643)	(49,893)	(15,809)	(6,932)	(21,336)
426891 I/C Sale of AR Fees			0	0	0	0	0	0	0	0	0	0	0	0
457100 SC Direct PT offset (reactive & sched in HFM as O&M)			0	0	0	0	0	0	0	0	0	0	0	0
457700 Allocated Employee Benefits Offset			0	0	0	0	0	0	0	0	0	(78)	78	0
500000 Suprvsn and Engrg - Steam Oper			0	(33)	0	9	(9)	15	0	(15)	0	7	(7)	10
502100 Fossil Steam Exp-Other			0	0	0	0	0	0	0	0	0	0	0	0
506000 Misc Fossil Power Expenses			109	(313)	81	25	(106)	10	12	(23)	16	25	(40)	19
511000 Maint Of Structures-Steam			0	0	0	0	0	0	0	0	3	0	(3)	0
514000 Maintenance - Misc Steam Plant			2	(12)	4	10	(13)	0	1	(1)	11	3	(14)	0
524000 Misc Expenses-Nuc Oper			0	(1)	0	0	0	0	0	0	0	0	0	0
528000 Maint Suprvsn and Enginrng-Nuc			0	0	0	0	0	0	0	0	0	0	0	0
532100 Maint Misc Nuclear Plt-Other			0	0	0	0	0	0	0	0	0	0	0	0
535000 Supervsn and Engrng-Hydro Oper			0	(2)	0	0	0	0	0	0	0	0	0	0
539000 Misc Hydraulic Expenses			0	0	0	0	0	0	0	0	0	0	0	0
543000 Maint-Reservoir,Dam & Waterway			0	0	0	0	0	0	0	0	0	0	0	0

546000 Suprvsn and Enginring-CT Oper	0	0	0	0	0	0	0	0	0	0	0	0
549000 Misc-Power Generation Expenses	0	(119)	1	6	(6)	0	0	0	0	0	0	0
551000 Suprvsn and Enginring-CT Maint	0	0	0	0	0	0	0	0	0	0	0	0
556000 System Cnts & Load Dispatching	0	0	0	0	0	0	0	0	0	0	0	0
557000 Other Expenses-Oper	590	(2,556)	766	550	(1,316)	93	330	(423)	104	1,161	(1,265)	211
561100 Load Dispatch-Reliability	0	(1)	0	0	0	0	0	0	0	0	0	0
561200 Load Dispatch-Mnitor&OprTrnSys	0	(6)	0	0	0	0	0	0	0	0	0	0
566000 Misc Trans Exp-Other	3	(24)	3	3	(6)	2	4	(7)	1	0	(1)	2
569100 Maint of Computer Hardware	0	(3)	0	0	0	0	0	0	0	0	0	0
569200 Maint Of Computer Software	0	0	0	1	(1)	0	1	(1)	0	1	(1)	0
571000 Maint Of Overhead Lines-Trans	0	0	0	0	0	0	0	0	0	11	(11)	2
580000 Supervsn and Engring-Dist Oper	0	(2)	0	6	(7)	15	4	(19)	5	6	(11)	8
581004 Load Dispatch-Dist of Elec	0	(1)	0	0	0	0	0	0	0	0	0	0
586000 Meter Expenses-Dist	75	(268)	118	37	(154)	52	66	(118)	47	27	(74)	42
587000 Cust Install Exp-Other Dist	0	0	0	0	0	0	0	0	0	28	(28)	0
588100 Misc Distribution Exp-Other	17,286	(101,099)	4,186	4,687	(8,874)	4,756	5,575	(10,331)	10,443	16,790	(27,233)	14,590
589000 Rents-Dist Oper	0	0	0	0	0	0	0	0	0	0	0	0
593000 Maint Overhd Lines-Other-Dist	0	(90)	90	0	(90)	0	521	(521)	0	0	0	274
593100 Right-Of-Way Maintenance-Dist	0	0	0	0	0	0	0	0	0	0	0	0
597000 Maintenance Of Meters-Dist	0	0	0	0	0	0	0	0	0	0	0	0
928053 Travel Expenses	0	0	0	0	0	0	0	0	0	0	0	0
Rounding	0	0	(6)	5	(1)	2	2	1	5	(7)	4	(4)
	44,395	(33,111)	13,404	(101,365)	(298,421)	(365,365)	(244,304)	(168,578)	291,194	312,256	92,252	104,554
	0	0	0	0	0	0	0	0	0	0	0	0
Taxes Other Than Income Taxes												
408040 NC Property Tax - Misc Non-Utility	2,470	2,470	2,470	2,470	(297)	2,294	2,294	2,294	2,296	2,295	2,292	2,296
408820 Misc Non-Utility Tax	0	0	25	0	0	0	0	0	0	0	0	0
Rounding	(1)	(1)	(1)	(2)	-	-	-	1	-	-	-	-
Total Variance	2,469	2,469	2,494	2,468	(297)	2,294	2,294	2,295	2,296	2,295	2,292	2,296
	0	0	0	0	0	0	0	0	0	0	0	0

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED JULY 30, 2018
AND THE TWELVE MONTHS ENDED JULY 30, 2017

		Total			
Account	Description	Prior 12 Months	Recent 12 Months	Variance	% Change
480000	Residential Sales-Gas	60,995,920	66,477,615	(5,481,695)	(8.25)%
480990	Gas Residential Sales-Unbilled	37,184	97,854	(60,670)	(62.00)%
481000	Industrial Sales-Gas	1,504,542	1,688,920	(184,378)	(10.92)%
481090	Gas Industrial Sales Unbilled	2,598	9,887	(7,289)	(73.72)%
481200	Gas Commercial Sales	20,979,625	23,905,287	(2,925,662)	(12.24)%
481290	Gas Commercial Sales Unbilled	27,973	(69,624)	97,597	140.18%
482000	Other Sales to Public Auth-Gas	2,221,882	2,387,042	(165,160)	(6.92)%
482090	Gas OPA Unbilled	2,165	26,449	(24,284)	(91.81)%
482200	Gas Public St Hwy Ltng	976	957	19	1.99%
484000	Interdepartmental Sales	24,018	34,050	(10,032)	(29.46)%
487001	Discounts Earn/Lost-Gas	0	0	0	-
488000	Misc Service Revenue-Gas	34,237	36,447	(2,210)	(6.06)%
488100	IC Misc Svc Reg Gas Reg	499,463	505,154	(5,691)	(1.13)%
489000	Transp Gas of Others	1,544,133	1,581,659	(37,526)	(2.37)%
489010	IC Gas Transp Rev Reg	522,072	522,072	0	-
489020	Intercompany Sales of Water	998,522	1,150,978	(152,456)	(13.25)%
489025	Comm Gas Transp Unbilled	2,195	(4,905)	7,100	144.75%
489030	Indust Gas Transp Only	2,824,357	2,913,574	(89,217)	(3.06)%
489035	Indust Gas Transp Unbilled	5,395	1,604	3,791	236.35%
489040	OPA Gas Transp Only	332,090	380,777	(48,687)	(12.79)%
489045	OPA Gas Transp Unbilled	(114)	4,066	(4,180)	(102.80)%
489200	Transportation Fees	0	0	0	-
495031	Gas Losses Damaged Lines	751	19,659	(18,908)	(96.18)%
496020	Provision for rate refund - Ta	0	(2,636,051)	2,636,051	100.00%
	Total	92,559,984	99,033,471	(6,473,487)	(6.54)%

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED JULY 30, 2018
AND THE TWELVE MONTHS ENDED JULY 30, 2017

		August			September		
Account	Description	2016	2017	Variance	2016	2017	Variance
480000	Residential Sales-Gas	2,209,946	2,213,687	(3,741)	2,285,251	2,318,917	(33,666)
480990	Gas Residential Sales-Unbilled	8,505	(30,421)	38,926	53,256	45,478	7,778
481000	Industrial Sales-Gas	34,444	34,285	159	35,817	41,036	(5,219)
481090	Gas Industrial Sales Unbilled	6,211	3,328	2,883	1,896	339	1,557
481200	Gas Commercial Sales	700,338	736,772	(36,434)	767,310	773,063	(5,753)
481290	Gas Commercial Sales Unbilled	(114,341)	(141,260)	26,919	115,366	107,859	7,507
482000	Other Sales to Public Auth-Gas	49,608	52,665	(3,057)	62,688	64,524	(1,836)
482090	Gas OPA Unbilled	7,561	5,618	1,943	8,219	7,352	867
482200	Gas Public St Hwy Ltng	77	78	(1)	81	81	0
484000	Interdepartmental Sales	(60)	32	(92)	25	31	(6)
487001	Discounts Earn/Lost-Gas	0	0	0	0	0	0
488000	Misc Service Revenue-Gas	1,324	1,950	(626)	2,244	2,805	(561)
488100	IC Misc Svc Reg Gas Reg	54,051	51,061	2,990	54,051	51,061	2,990
489000	Transp Gas of Others	125,969	132,524	(6,555)	118,579	112,035	6,544
489010	IC Gas Transp Rev Reg	43,506	43,506	0	43,506	43,506	0
489020	Intercompany Sales of Water	53,419	50,450	2,969	56,062	53,358	2,704
489025	Comm Gas Transp Unbilled	(6,339)	(7,564)	1,225	5,612	5,779	(167)
489030	Indust Gas Transp Only	202,765	209,290	(6,525)	195,359	192,051	3,308
489035	Indust Gas Transp Unbilled	9,003	8,831	172	2,022	(641)	2,663
489040	OPA Gas Transp Only	9,358	10,182	(824)	10,085	12,499	(2,414)
489045	OPA Gas Transp Unbilled	1,019	1,000	19	1,225	1,087	138
489200	Transportation Fees	0	0	0	0	0	0
495031	Gas Losses Damaged Lines	68	0	68	82	26	56
496020	Provision for rate refund - Ta	0	0	0	0	0	0
	Total	3,396,432	3,376,014	20,418	3,818,736	3,832,246	(13,510)

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED JULY 30, 2018
AND THE TWELVE MONTHS ENDED JULY 30, 2017

		October			November		
Account	Description	2016	2017	Variance	2016	2017	Variance
480000	Residential Sales-Gas	2,400,394	2,356,216	44,178	3,613,804	4,699,655	(1,085,851)
480990	Gas Residential Sales-Unbilled	489,483	994,726	(505,243)	1,763,936	1,402,412	361,524
481000	Industrial Sales-Gas	41,455	38,396	3,059	75,210	121,506	(46,296)
481090	Gas Industrial Sales Unbilled	14,648	26,470	(11,822)	41,373	43,051	(1,678)
481200	Gas Commercial Sales	829,316	779,382	49,934	1,220,150	1,649,804	(429,654)
481290	Gas Commercial Sales Unbilled	87,180	234,977	(147,797)	723,380	723,684	(304)
482000	Other Sales to Public Auth-Gas	68,163	64,321	3,842	127,831	164,495	(36,664)
482090	Gas OPA Unbilled	23,842	71,524	(47,682)	135,981	112,937	23,044
482200	Gas Public St Hwy Ltng	83	78	5	79	77	2
484000	Interdepartmental Sales	53	79	(26)	190	161	29
487001	Discounts Earn/Lost-Gas	0	0	0	0	0	0
488000	Misc Service Revenue-Gas	7,215	9,154	(1,939)	7,731	6,322	1,409
488100	IC Misc Svc Reg Gas Reg	54,051	51,061	2,990	54,051	51,061	2,990
489000	Transp Gas of Others	131,098	142,058	(10,960)	145,183	148,348	(3,165)
489010	IC Gas Transp Rev Reg	43,506	43,506	0	43,506	43,506	0
489020	Intercompany Sales of Water	69,723	68,364	1,359	88,926	108,255	(19,329)
489025	Comm Gas Transp Unbilled	5,280	13,403	(8,123)	40,907	37,494	3,413
489030	Indust Gas Transp Only	212,187	214,906	(2,719)	245,074	253,756	(8,682)
489035	Indust Gas Transp Unbilled	35,273	60,376	(25,103)	97,942	84,314	13,628
489040	OPA Gas Transp Only	15,646	23,170	(7,524)	33,540	40,413	(6,873)
489045	OPA Gas Transp Unbilled	4,165	11,610	(7,445)	23,285	17,324	5,961
489200	Transportation Fees	0	0	0	0	0	0
495031	Gas Losses Damaged Lines	29	64	(35)	14	572	(558)
496020	Provision for rate refund - Ta	0	0	0	0	0	0
	Total	4,532,790	5,203,841	(671,051)	8,482,093	9,709,147	(1,227,054)

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED JULY 30, 2018
AND THE TWELVE MONTHS ENDED JULY 30, 2017

		December			January		
Account	Description	2016	2017	Variance	2017	2018	Variance
480000	Residential Sales-Gas	8,483,213	8,340,117	143,096	12,121,117	13,132,271	(1,011,154)
480990	Gas Residential Sales-Unbilled	2,740,272	2,499,849	240,423	(1,274,961)	(1,045,741)	(229,220)
481000	Industrial Sales-Gas	223,741	240,524	(16,783)	357,952	386,075	(28,123)
481090	Gas Industrial Sales Unbilled	(7,363)	(4,020)	(3,343)	(12,636)	(18,173)	5,537
481200	Gas Commercial Sales	2,846,428	3,005,622	(159,194)	4,373,835	4,843,645	(469,810)
481290	Gas Commercial Sales Unbilled	894,537	664,424	230,113	(639,671)	(481,813)	(157,858)
482000	Other Sales to Public Auth-Gas	322,503	304,155	18,348	487,758	529,945	(42,187)
482090	Gas OPA Unbilled	34,854	69,551	(34,697)	(24,923)	(116,309)	91,386
482200	Gas Public St Hwy Ltng	84	80	4	84	85	(1)
484000	Interdepartmental Sales	901	4,259	(3,358)	6,388	6,726	(338)
487001	Discounts Earn/Lost-Gas	0	0	0	0	0	0
488000	Misc Service Revenue-Gas	2,631	2,422	209	2,309	2,236	73
488100	IC Misc Svc Reg Gas Reg	(74,168)	2,850	(77,018)	51,061	42,580	8,481
489000	Transp Gas of Others	127,866	139,934	(12,068)	133,416	147,775	(14,359)
489010	IC Gas Transp Rev Reg	43,506	43,506	0	43,506	43,506	0
489020	Intercompany Sales of Water	141,187	151,543	(10,356)	143,569	172,211	(28,642)
489025	Comm Gas Transp Unbilled	35,666	38,494	(2,828)	(25,436)	(26,085)	649
489030	Indust Gas Transp Only	310,536	301,071	9,465	310,363	343,666	(33,303)
489035	Indust Gas Transp Unbilled	(36,957)	(9,303)	(27,654)	(10,938)	(41,236)	30,298
489040	OPA Gas Transp Only	63,182	59,371	3,811	56,374	67,643	(11,269)
489045	OPA Gas Transp Unbilled	1,679	12,663	(10,984)	(1,050)	(18,991)	17,941
489200	Transportation Fees	0	0	0	0	(2)	2
495031	Gas Losses Damaged Lines	0	218	(218)	218	117	101
496020	Provision for rate refund - Ta	0	0	0	0	(588,711)	588,711
	Total	16,154,298	15,867,330	286,968	16,098,335	17,381,420	(1,283,085)

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED JULY 30, 2018
AND THE TWELVE MONTHS ENDED JULY 30, 2017

		February			March		
Account	Description	2017	2018	Variance	2017	2018	Variance
480000	Residential Sales-Gas	8,828,699	10,339,872	(1,511,173)	7,836,503	7,453,246	383,257
480990	Gas Residential Sales-Unbilled	(401,306)	(1,258,027)	856,721	(938,316)	159,993	(1,098,309)
481000	Industrial Sales-Gas	239,643	292,172	(52,529)	231,722	203,083	28,639
481090	Gas Industrial Sales Unbilled	(10,038)	(25,437)	15,399	(115)	12,904	(13,019)
481200	Gas Commercial Sales	3,027,050	3,728,266	(701,216)	2,654,470	2,809,229	(154,759)
481290	Gas Commercial Sales Unbilled	(87,549)	(306,544)	218,995	(211,281)	(24,421)	(186,860)
482000	Other Sales to Public Auth-Gas	350,021	401,649	(51,628)	304,083	292,314	11,769
482090	Gas OPA Unbilled	(3,882)	(64,160)	60,278	3,339	79,980	(76,641)
482200	Gas Public St Hwy Ltng	79	78	1	83	81	2
484000	Interdepartmental Sales	6,496	8,445	(1,949)	5,456	6,070	(614)
487001	Discounts Earn/Lost-Gas	0	0	0	0	0	0
488000	Misc Service Revenue-Gas	1,679	1,976	(297)	1,361	2,303	(942)
488100	IC Misc Svc Reg Gas Reg	51,061	42,580	8,481	51,061	85,160	(34,099)
489000	Transp Gas of Others	121,297	123,614	(2,317)	129,676	138,802	(9,126)
489010	IC Gas Transp Rev Reg	43,506	43,506	0	43,506	43,506	0
489020	Intercompany Sales of Water	108,794	120,195	(11,401)	115,170	152,563	(37,393)
489025	Comm Gas Transp Unbilled	(9,165)	(18,288)	9,123	(6,124)	(2,731)	(3,393)
489030	Indust Gas Transp Only	258,924	281,574	(22,650)	283,595	306,852	(23,257)
489035	Indust Gas Transp Unbilled	(40,198)	(58,273)	18,075	15,403	21,872	(6,469)
489040	OPA Gas Transp Only	42,123	45,514	(3,391)	43,864	51,699	(7,835)
489045	OPA Gas Transp Unbilled	(5,831)	(10,592)	4,761	1,666	12,494	(10,828)
489200	Transportation Fees	0	2	(2)	0	0	0
495031	Gas Losses Damaged Lines	0	13,685	(13,685)	365	883	(518)
496020	Provision for rate refund - Ta	0	(469,319)	469,319	0	(433,381)	433,381
	Total	12,521,403	13,232,488	(711,085)	10,565,487	11,372,501	(807,014)

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED JULY 30, 2018
AND THE TWELVE MONTHS ENDED JULY 30, 2017

		April			May		
Account	Description	2017	2018	Variance	2017	2018	Variance
480000	Residential Sales-Gas	4,984,546	7,158,228	(2,173,682)	3,398,120	3,715,099	(316,979)
480990	Gas Residential Sales-Unbilled	(1,116,821)	(1,183,928)	67,107	(847,640)	(1,489,893)	642,253
481000	Industrial Sales-Gas	135,456	185,536	(50,080)	60,187	75,665	(15,478)
481090	Gas Industrial Sales Unbilled	(21,402)	(25,972)	4,570	(2,256)	(4,562)	2,306
481200	Gas Commercial Sales	1,808,528	2,721,970	(913,442)	1,151,609	1,309,181	(157,572)
481290	Gas Commercial Sales Unbilled	(470,567)	(473,678)	3,111	(182,113)	(269,300)	87,187
482000	Other Sales to Public Auth-Gas	205,397	280,594	(75,197)	113,921	113,606	315
482090	Gas OPA Unbilled	(142,446)	(104,376)	(38,070)	(15,999)	(35,969)	19,970
482200	Gas Public St Hwy Ltng	80	79	1	82	78	4
484000	Interdepartmental Sales	3,314	5,204	(1,890)	976	2,882	(1,906)
487001	Discounts Earn/Lost-Gas	0	0	0	0	0	0
488000	Misc Service Revenue-Gas	1,603	2,041	(438)	2,671	1,806	865
488100	IC Misc Svc Reg Gas Reg	51,061	0	51,061	51,061	42,580	8,481
489000	Transp Gas of Others	120,895	134,169	(13,274)	131,457	116,181	15,276
489010	IC Gas Transp Rev Reg	43,506	43,506	0	43,506	43,506	0
489020	Intercompany Sales of Water	68,010	104,805	(36,795)	57,124	60,321	(3,197)
489025	Comm Gas Transp Unbilled	(26,006)	(24,163)	(1,843)	(8,366)	(15,445)	7,079
489030	Indust Gas Transp Only	211,193	253,535	(42,342)	214,632	198,410	16,222
489035	Indust Gas Transp Unbilled	(55,966)	(48,519)	(7,447)	(424)	(14,297)	13,873
489040	OPA Gas Transp Only	20,261	37,094	(16,833)	17,821	12,770	5,051
489045	OPA Gas Transp Unbilled	(20,944)	(16,223)	(4,721)	(2,273)	(5,997)	3,724
489200	Transportation Fees	0	0	0	0	0	0
495031	Gas Losses Damaged Lines	0	44	(44)	(25)	72	(97)
496020	Provision for rate refund - Ta	0	(501,976)	501,976	0	(254,099)	254,099
	Total	5,799,698	8,547,970	(2,748,272)	4,184,071	3,602,595	581,476

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
COMPARISON OF GAS REVENUE BALANCES
FOR THE TWELVE MONTHS ENDED JULY 30, 2018
AND THE TWELVE MONTHS ENDED JULY 30, 2017

		June			July		
Account	Description	2017	2018	Variance	2017	2018	Variance
480000	Residential Sales-Gas	2,502,566	2,438,671	63,895	2,331,761	2,311,636	20,125
480990	Gas Residential Sales-Unbilled	(361,564)	(11,734)	(349,830)	(77,660)	15,140	(92,800)
481000	Industrial Sales-Gas	36,231	35,022	1,209	32,684	35,620	(2,936)
481090	Gas Industrial Sales Unbilled	(3,507)	1,213	(4,720)	(4,213)	746	(4,959)
481200	Gas Commercial Sales	838,743	794,201	44,542	761,848	754,152	7,696
481290	Gas Commercial Sales Unbilled	(156,323)	(106,366)	(49,957)	69,355	2,814	66,541
482000	Other Sales to Public Auth-Gas	69,999	64,621	5,378	59,910	54,153	5,757
482090	Gas OPA Unbilled	(22,565)	(880)	(21,685)	(1,816)	1,181	(2,997)
482200	Gas Public St Hwy Ltng	84	82	2	80	80	0
484000	Interdepartmental Sales	239	143	96	40	18	22
487001	Discounts Earn/Lost-Gas	0	0	0	0	0	0
488000	Misc Service Revenue-Gas	1,702	1,962	(260)	1,767	1,470	297
488100	IC Misc Svc Reg Gas Reg	51,061	42,580	8,481	51,061	42,580	8,481
489000	Transp Gas of Others	132,968	123,263	9,705	125,729	122,956	2,773
489010	IC Gas Transp Rev Reg	43,506	43,506	0	43,506	43,506	0
489020	Intercompany Sales of Water	50,821	55,117	(4,296)	45,717	53,796	(8,079)
489025	Comm Gas Transp Unbilled	(8,007)	(6,046)	(1,961)	4,173	247	3,926
489030	Indust Gas Transp Only	200,219	170,050	30,169	179,510	188,413	(8,903)
489035	Indust Gas Transp Unbilled	(4,685)	(2,302)	(2,383)	(5,080)	782	(5,862)
489040	OPA Gas Transp Only	10,057	10,331	(274)	9,779	10,091	(312)
489045	OPA Gas Transp Unbilled	(2,910)	(530)	(2,380)	(145)	221	(366)
489200	Transportation Fees	0	0	0	0	0	0
495031	Gas Losses Damaged Lines	0	1,724	(1,724)	0	2,254	(2,254)
496020	Provision for rate refund - Ta	0	(196,486)	196,486	0	(192,079)	192,079
	Total	3,378,635	3,458,142	(79,507)	3,628,006	3,449,777	178,229

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-029

REQUEST:

Provide a copy of each cost-of-service study and billing analysis filed with Duke Kentucky's rate application in Excel spreadsheet format with all formulas intact and unprotected and with all columns and rows accessible.

RESPONSE:

See STAFF-DR-01-029 Attachment.

PERSON RESPONSIBLE: James E. Ziolkowski

STAFF-DR-01-029
EXCEL
ATTACHMENT

PROVIDED ON CD

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-030

REQUEST:

Provide the following expense-account data:

a. A schedule showing a comparison of the balance in Duke Kentucky's operating expense accounts for each month of the most recent 12 months for which information is available at the time the application is filed to the same month of the preceding 12-month period for each account or subaccount included in Duke Kentucky's chart of accounts. See Schedule 30.

b. A schedule, in comparative form, showing the operating expense account balance for the base period and each of the three most recent calendar years for each account or subaccount included in Duke Kentucky's annual report. Show the percentage of increase or decrease of each year over the prior year.

c. A listing, with descriptions, of all activities, initiatives or programs undertaken or continued by Duke Kentucky since its last general rate case for the purpose of minimizing costs or improving the efficiency of its operations or maintenance activities.

RESPONSE:

a. See STAFF-DR-01-030(a) Attachment.

b. See STAFF-DR-01-030(b) Attachment.

c. The Company is always adapting to new efficiencies in our processes even where there are not expressly written initiatives or programs. Duke Energy Kentucky routinely files reports with this Commission that describe, among other things, such efficiencies implemented through best practices adopted. These reports are filed with this Commission and publicly available in the post-case correspondence in Case No. 2011-00124, available at

http://psc.ky.gov/PSC_WebNet/ViewCaseFilings.aspx?case=2011-00124

The Company also made similar reporting filings with the Commission as part of commitments made in Case No 2005-00228. These reports are available in both the case files and in the post case correspondence available here: http://psc.ky.gov/PSC_WebNet/ViewCaseFilings.aspx?case=2005-00228; and http://psc.ky.gov/PSC_WebNet/ViewCaseFilings.aspx?case=2005-00228.

In addition to the initiatives outlined in the documents referenced above, the following are some examples of cost-saving programs undertaken over the period:

- Since 2009, Operation & Maintenance costs for Duke Energy Kentucky have remained relatively flat, overcoming the cost of inflation, due to several initiatives the Company has executed on in order to minimize costs to customers.
- As discussed in the direct testimony of Gary J. Hebbeler, Duke Energy Kentucky has aggressively investigated and, where justified, implemented new products, technologies, and work methods to increase our productivity. Duke Energy Kentucky and Ohio participate in the AGA's Gas Utility Operations Best Practices Benchmarking

Program. In this program, gas distribution companies from the United States and Canada routinely benchmark three to five distribution operations topics each year. Duke Energy Kentucky has implemented process improvements and utilized new technology, materials, and equipment as a result of what it has learned through participating in this program. The Company also participates in the AGA Peer to Peer review program. This voluntary safety initiative is for local natural gas utilities throughout North America. The National AGA Peer Review Program is a peer-to-peer safety and operational practices review program that allows AGA member companies to observe their peers, share leading practices and identify opportunities to better serve customers and communities.

- Corporate cost reductions through elimination of redundant processes and workforce planning, driving reductions in Labor and contract costs.

PERSON RESPONSIBLE: Michael Covington – a., b.
Gary Hebbeler – c.

STAFF-DR-01-030(a)
EXCEL
ATTACHMENT

PROVIDED ON CD

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
COMPARISON OF GAS EXPENSE ACCOUNT BALANCES
FOR THE TWELVE MONTHS ENDED JULY 30, 2018
AND THE TWELVE MONTHS ENDED JULY 30, 2017

Account	Description	Total Prior 12 Months	Total Recent 12 Months	Variance	% Change
403002	Depr-Expense	11,392,832	12,009,527	(616,695)	(5.14)%
403150	Depreciation Expense - ARO	0	0	0	-
404200	Amort Of Elec Plt - Software	1,084,826	1,768,089	(683,263)	(38.64)%
407355	DSM Deferral - Gas	901,105	(1,278,239)	2,179,344	170.50%
408121	Taxes Property-Operating	3,545,151	2,858,838	686,313	24.01%
408150	State Unemployment Tax	3,133	3,595	(462)	(12.85)%
408151	Federal Unemployment Tax	2,171	2,939	(768)	(26.13)%
408152	Employer FICA Tax	347,312	406,453	(59,141)	(14.55)%
408205	Highway Use Tax	347	250	97	38.80%
408470	Franchise Tax	15,073	4,558	10,515	230.69%
408700	Fed Social Security Tax-Elec	1,000	1,000	0	-
408800	Federal Highway Use Tax-Elec	160	168	(8)	(4.76)%
408851	Sales & Use Tax Exp	(94)	(1,790)	1,696	94.75%
408960	Allocated Payroll Taxes	233,781	239,083	(5,302)	(2.22)%
409102	Sit Exp-Utility	1,319,901	169,578	1,150,323	678.34%
409104	Current State Income Tax - PY	(1,198,974)	(1,092,775)	(106,199)	(9.72)%
409190	Federal Income Tax-Electric-CY	6,715,988	935,203	5,780,785	618.13%
409191	Fed Income Tax-Electric-PY	(6,390,376)	(6,934,419)	544,043	7.85%
409195	UTP Tax Expense: Fed Util-PY	0	12,269	(12,269)	(100.00)%
410100	DFIT: Utility: Current Year	6,111,426	7,555,208	(1,443,782)	(19.11)%
410102	DSIT: Utility: Current Year	1,403,801	1,340,758	63,043	4.70%
410105	DFIT: Utility: Prior Year	1,001,363	8,501,964	(7,500,601)	(88.22)%
410106	DSIT: Utility: Prior Year	346,773	1,374,757	(1,027,984)	(74.78)%
411050	Accretion Expense ARO	0	0	0	-
411100	DFIT: Utility: Curr Year CR	(9,248,298)	(4,649,153)	(4,599,145)	(98.92)%
411101	DSIT: Utility: Curr Year CR	(1,756,884)	(843,220)	(913,664)	(108.35)%
411102	DFIT: Utility: Prior Year CR	4,979,799	(2,113,662)	7,093,461	335.60%
411103	DSIT: Utility: Prior Year CR	813,865	(365,505)	1,179,370	322.67%
426510	Other	478	(478)	956	200.00%
426891	IC Sale of AR Fees VIE	111,791	154,148	(42,357)	(27.48)%
711000	Gas Boiler Labor	5,759	8,645	(2,886)	(32.92)%
712000	Gas Production-Other Power Ex	7,425	13,658	(6,233)	(45.64)%
717000	Liq Petro Gas Exp-Vapor Proc	94,182	104,685	(10,503)	(10.03)%
728000	Liquid Petroleum Gas	371,014	1,664,737	(1,293,723)	(77.71)%
735000	Gas Misc Production Exp	37,450	68,117	(31,667)	(45.82)%
742000	Maint Gas Production Equipmen	46,015	130,460	(84,445)	(64.73)%
801000	Purchases Gas & NGL	32,875,275	39,102,716	(6,227,441)	(15.93)%
801001	Purchases Gas & NGL-Aff	1,204,951	2,001,995	(797,044)	(39.81)%
805002	Unrecovered Purchase Gas Adj	2,570,402	(1,750,723)	4,321,125	246.82%
805003	Purchase Gas Cost Unbilled Rev	41,707	15,573	26,134	167.82%
807000	Gas Purchased Expenses	366,627	533,265	(166,638)	(31.25)%
807100	I/C Gas Purchased Expenses	40,769	17,203	23,566	136.99%
813001	Other Gas Supply Expenses	554,832	319,215	235,617	73.81%
850001	Operation Supv & Eng-Tran	0	0	0	-
870000	Distribution Sys Ops-Supv/Eng	(1,603)	0	(1,603)	-
871000	Distribution Load Dispatching	169,879	141,522	28,357	20.04%
874000	Mains And Services	3,264,799	1,697,707	1,567,092	92.31%
875000	Measuring And Reg Stations-Ge	67,229	7,017	60,212	858.09%
876000	Measuring & Reg Station-Indus	42,630	10,722	31,908	297.59%
878000	Meter And House Regulator Exp	2,048,725	1,517,948	530,777	34.97%
879000	Customer Installation Expense	1,662,725	1,099,795	562,930	51.18%
880000	Gas Distribution-Other Expense	2,577,399	2,072,349	505,050	24.37%
885000	Maintenance Dist. System Fac - Supv / Eng	(2,992)	0	(2,992)	-
887000	Maintenance of Mains	933,317	1,395,443	(462,126)	(33.12)%
889000	Maint-Meas/Reg Stn Equip-Gas	43,950	37,428	6,522	17.43%
892000	Maintenance of Services	693,462	615,117	78,345	12.74%
893000	Maint - Meters And House Reg	393,430	354,391	39,039	11.02%
894000	Maint-Other Distribution Equip	(9,237)	(35,357)	26,120	73.88%
901000	Supervision-Cust Accts	543,388	508,989	34,409	6.76%
902000	Meter Reading Expense	519,154	383,039	136,115	35.54%
903000	Cust Records & Collection Exp	1,696,383	1,734,104	(37,721)	(2.18)%
903100	Cust Contracts & Orders-Local	174,315	139,674	34,641	24.80%
903200	Cust Billing & Acct	967,724	736,338	231,386	31.42%
903250	Customer Billing-Common	0	0	0	-
903300	Cust Collecting-Local	147,960	143,979	3,981	2.76%
903400	Cust Receiv & Collect Exp-Edp	26,484	28,980	(2,496)	(8.61)%
903891	IC Collection Agent Revenue	(76,313)	(46,557)	(29,756)	(63.91)%
904001	BAD DEBT EXPENSE	181,827	3,573	178,254	4988.92%
904003	Cust Acctg-Loss On Sale-A/R	(407,539)	0	(407,539)	-
904891	IC Loss on Sale of AR VIE	272,498	0	272,498	-
905000	Misc Customer Accts Expenses	423	277	146	52.71%
908000	Cust Asst Exp-Conservation Pro	1	13	(12)	(92.31)%
908150	Commer/Indust Assistance Exp	0	0	0	-
908160	Cust Assist Exp-General	154,042	147,131	6,911	4.70%
909650	Misc Advertising Expenses	745	2,356	(1,611)	(68.38)%
910000	Misc Cust Serv/Inform Exp	189,745	185,349	4,396	2.37%
910100	Exp-Rs Reg Prod/Svces-CstAccts	138,181	96,673	41,508	42.94%
911000	Supervision	0	241	(241)	(100.00)%
912000	Demonstrating & Selling Exp	95,789	129,428	(33,639)	(25.99)%
913001	Advertising Expense	4,025	10,835	(6,810)	(62.85)%
920000	A & G Salaries	1,867,919	2,054,226	(186,307)	(9.07)%
921100	Employee Expenses	102,738	110,437	(7,699)	(6.97)%
921101	Employee Exp - NC	0	14	(14)	(100.00)%
921110	Relocation Expenses	2,141	670	1,471	219.55%
921200	Office Expenses	178,754	163,396	15,358	9.40%
921300	Telephone And Telegraph Exp	78	30	48	160.00%
921400	Computer Services Expenses	198,675	179,710	18,965	10.55%
921540	Computer Rent (Go Only)	102,149	167,384	(65,235)	(38.97)%
921600	Other	494	1,143	(649)	(56.78)%
921980	Office Supplies & Expenses	361,335	499,967	(138,632)	(27.73)%
922000	Admin. Exp Transfer	517	295	222	75.25%
923000	Outside Services Employed	725,013	1,544,645	(818,632)	(53.00)%
923980	Outside Services Employee &	(20,182)	(11,673)	(8,509)	(72.89)%
924000	Property Insurance	1,224	864	360	41.67%
924050	Inter-Co Prop Ins Exp	70,199	31,929	38,270	119.86%
924980	Property Insurance For Corp.	57,040	53,755	3,285	6.11%
925000	Injuries & Damages	112,922	54,205	58,717	108.32%
925051	INTER-CO GEN LIAB EXP	261,400	149,783	111,617	74.52%
925200	Injuries And Damages-Other	3,032	2,460	572	23.25%
925300	Environmental Inj & Damages	147,702	101,605	46,097	45.37%
925980	Injuries And Damages For Corp.	4,386	4,331	55	1.27%
926000	EMPL PENSIONS AND BENEFITS	1,070,852	1,981,672	(910,820)	(45.96)%
926430	Employees'Recreation Expense	26	100	(74)	(74.00)%
926600	Employee Benefits-Transferred	588,392	813,875	(225,483)	(27.70)%
926999	Non Serv Pension (ASU 2017-07)	0	(183,206)	183,206	100.00%
928000	Regulatory Expenses (Go)	16	0	16	-
928006	State Reg Comm Proceeding	201,316	185,875	15,441	8.31%
929000	Duplicate Chrgs-Enrgy To Exp	(37,984)	(52,948)	14,964	28.26%
929500	Admin Exp Transf	(240,920)	(219,135)	(21,785)	(9.94)%
930150	Miscellaneous Advertising Exp	7,279	18,246	(10,967)	(60.11)%
930200	Misc General Expenses	220,475	245,979	(25,504)	(10.37)%
930210	Industry Association Dues	22,079	19,329	2,750	14.23%
930220	Exp Of Servicing Securities	(212)	71	(283)	(398.59)%
930230	Dues To Various Organizations	18,634	20,066	(1,432)	(7.14)%
930240	Director'S Expenses	18,399	17,910	489	2.73%
930250	Buy\Sell Transf Employee Homes	8,911	4,478	4,433	99.00%
930700	Research & Development	1,437	1,279	158	12.35%
930940	General Expenses	586	1,025	(439)	(42.83)%
931001	Rents-A&G	204,520	135,897	68,623	50.50%
931008	A&G Rents-IC	289,340	258,794	30,546	11.80%
932000	Maintenance Of Gen Plant-Gas	5,248	8,869	(3,621)	(40.83)%
935100	Maint General Plant-Elec	(1,884)	213	(2,097)	(984.51)%
935200	Cust Infor & Computer Control	710	2,043	(1,333)	(65.25)%

		August			September		
Account	Description	2016	2017	Variance	2016	2017	Variance
403002	Depr-Expense	944,000	980,227	(36,227)	926,275	967,095	(40,820)
403150	Depreciation Expense - ARO	0	0	0	0	0	0
404200	Amort Of Elec Plt - Software	58,286	114,441	(56,155)	56,601	148,030	(91,429)
407355	DSM Deferral - Gas	(17,891)	(68,743)	50,852	(26,173)	(71,405)	45,232
408121	Taxes Property-Operating	307,167	244,725	62,442	307,167	227,667	79,500
408150	State Unemployment Tax	116	918	(802)	221	149	72
408151	Federal Unemployment Tax	51	(240)	291	78	(5)	83
408152	Employer FICA Tax	26,919	27,030	(111)	36,457	46,913	(10,456)
408205	Highway Use Tax	0	0	0	0	0	0
408470	Franchise Tax	0	386	(386)	0	386	(386)
408700	Fed Social Security Tax-Elec	0	0	0	(3,000)	(4,000)	1,000
408800	Federal Highway Use Tax-Elec	1	1	0	1	2	(1)
408851	Sales & Use Tax Exp	0	(10)	10	(30)	11	(41)
408960	Allocated Payroll Taxes	22,297	12,650	9,647	20,989	14,888	6,101
409102	Sit Exp-Utility	(53,542)	(257,011)	203,469	690,876	(69,781)	760,657
409104	Current State Income Tax - PY	(1,008,457)	(1,376,717)	388,260	0	0	0
409190	Federal Income Tax-Electric-CY	(154,720)	(1,798,383)	1,643,663	4,713,458	(1,438,668)	6,152,126
409191	Fed Income Tax-Electric-PY	(6,390,376)	(8,723,961)	2,333,585	0	0	0
409195	UTP Tax Expense: Fed Util-PY	0	0	0	0	12,289	(12,289)
410100	DFIT: Utility: Current Year	656,674	2,351,617	(1,694,943)	(4,910,475)	1,320,747	(6,231,222)
410102	DSIT: Utility: Current Year	104,337	358,074	(253,737)	(787,298)	196,709	(984,007)
410105	DFIT: Utility: Prior Year	1,001,688	8,390,790	(7,389,102)	0	0	0
410106	DSIT: Utility: Prior Year	161,617	1,353,805	(1,192,188)	0	0	0
411050	Accretion Expense ARO	0	0	0	0	0	0
411100	DFIT: Utility: Curr Year CR	(456,652)	(577,456)	120,806	(69,240)	(168,397)	99,157
411101	DSIT: Utility: Curr Year CR	(107,282)	(197,346)	90,064	71,974	(180,422)	252,396
411102	DFIT: Utility: Prior Year CR	5,044,279	(144,331)	5,188,610	0	(177,968)	177,968
411103	DSIT: Utility: Prior Year CR	813,865	(23,287)	837,152	0	0	0
426510	Other	0	0	0	446,017	(478)	446,495
426891	IC Sale of AR Fees VIE	8,606	9,607	(1,001)	8,498	9,597	(1,099)
711000	Gas Boiler Labor	105	2	103	0	2	(2)
712000	Gas Production-Other Power Ex	324	9	315	24	114	(90)
717000	Liq Petro Gas Exp-Vapor Proc	2,077	3,048	(971)	8,606	4,462	4,144
728000	Liquid Petroleum Gas	0	0	0	0	0	0
735000	Gas Misc Production Exp	6,843	5,587	1,256	1,216	9,818	(8,602)
742000	Maint Gas Production Equipmen	310	594	(284)	79	6,954	(6,875)
801000	Purchases Gas & NGL	837,031	1,079,599	(242,568)	844,950	1,243,770	(398,820)
801001	Purchases Gas & NGL-Aff	8,994	159,846	(150,852)	9,680	159,628	(149,948)
805002	Unrecovered Purchase Gas Adj	(191,682)	(548,798)	357,116	(74,532)	(627,893)	553,361
805003	Purchase Gas Cost Unbilled Rev	(43,142)	(110,357)	67,215	118,951	103,221	15,730
807000	Gas Purchased Expenses	32,803	32,083	720	22,230	37,417	(15,187)
807100	I/C Gas Purchased Expenses	823	613	210	992	1,063	(71)
813001	Other Gas Supply Expenses	37,572	39,620	(2,048)	43,313	28,070	15,243
850001	Operation Supv & Eng-Tran	0	0	0	0	0	0
870000	Distribution Sys Ops-Supv/Eng	1,346	0	1,346	(797)	0	(797)
871000	Distribution Load Dispatching	15,783	12,912	2,871	14,466	12,412	2,054
874000	Mains And Services	251,591	(270,075)	521,666	431,389	227,587	203,802
875000	Measuring And Reg Stations-Ge	11	544	(533)	17	11	6
876000	Measuring & Reg Station-Indus	10,413	1,476	8,937	6,170	673	5,497
878000	Meter And House Regulator Exp	138,763	479,499	(340,736)	145,682	118,841	26,841
879000	Customer Installation Expense	226,181	72,451	153,730	266,604	93,654	172,950
880000	Gas Distribution-Other Expense	217,448	235,842	(18,394)	237,465	405,659	(168,194)
885000	Maintenance Dist. System Fac - Supv / Eng	2,019	0	2,019	(1,192)	0	(1,192)
887000	Maintenance of Mains	67,146	72,972	(5,826)	95,200	89,418	5,782
889000	Maint-Meas Reg Stn Equip-Gas	912	4,851	(3,939)	2,262	6,244	(3,982)
892000	Maintenance of Services	90,539	32,138	58,401	27,679	74,693	(47,014)
893000	Maint - Meters And House Reg	25,720	19,809	5,911	57,101	27,837	29,264
894000	Maint-Other Distribution Equip	(32,462)	29,942	(62,404)	3,697	27,913	(24,216)
901000	Supervision-Cust Accts	29,465	46,037	(16,572)	41,990	55,840	(13,850)
902000	Meter Reading Expense	50,603	29,102	21,501	62,844	49,778	13,066
903000	Cust Records & Collection Exp	173,653	161,677	11,976	160,463	134,205	26,258
903100	Cust Contracts & Orders-Local	10,606	11,986	(1,380)	39,751	13,509	26,242
903200	Cust Billing & Acct	47,340	53,223	(5,883)	167,830	61,783	106,047
903250	Customer Billing-Common	0	0	0	(278,076)	0	(278,076)
903300	Cust Collecting-Local	10,091	11,998	(1,907)	33,648	13,142	20,506
903400	Cust Receiv & Collect Exp-Edp	1,236	2,731	(1,495)	1,514	2,099	(585)
903891	IC Collection Agent Revenue	0	(3,314)	3,314	0	(3,044)	3,044
904001	BAD DEBT EXPENSE	0	(2,749)	2,749	279,226	(1,391)	280,617
904003	Cust Acctg-Loss On Sale-A/R	21,769	0	21,769	(429,308)	0	(429,308)
904891	IC Loss on Sale of AR VIE	(2,616)	0	(2,616)	(2,982)	0	(2,982)
905000	Misc Customer Accts Expenses	40	22	18	45	9	36
908000	Cust Asst Exp-Conservation Pro	0	1	(1)	0	0	0
908150	Commer/Indust Assistance Exp	0	0	0	0	0	0
908160	Cust Assist Exp-General	13,744	10,652	3,092	13,353	10,917	2,436
909650	Misc Advertising Expenses	336	316	20	0	0	0
910000	Misc Cust Serv/Inform Exp	14,798	11,686	3,112	16,558	16,148	410
910100	Exp-Rs Reg Prod/Svces-CstAccts	26,760	11,259	15,501	17,641	10,205	7,436
911000	Supervision	0	0	0	0	0	0
912000	Demonstrating & Selling Exp	6,014	7,297	(1,283)	3,927	10,068	(6,141)
913001	Advertising Expense	(1)	411	(412)	2	216	(214)
920000	A & G Salaries	122,412	141,466	(19,054)	122,160	115,454	6,706
921100	Employee Expenses	3,434	12,392	(8,958)	13,058	21,681	(8,623)
921101	Employee Exp - NC	0	0	0	0	0	0
921110	Relocation Expenses	841	123	718	199	0	199
921200	Office Expenses	15,269	34,404	(19,135)	13,130	(31,045)	44,175
921300	Telephone And Telegraph Exp	3	6	(3)	7	0	7
921400	Computer Services Expenses	18,897	(9,537)	28,434	12,907	17,483	(4,576)
921540	Computer Rent (Go Only)	5,768	10,529	(4,761)	22,043	10,624	11,419
921900	Other	39	12	27	127	454	(327)
921980	Office Supplies & Expenses	33,677	38,752	(5,075)	28,761	26,586	2,175
922000	Admin Exp Transfer	473	0	473	0	0	0
923000	Outside Services Employed	39,266	69,912	(30,646)	(37,854)	177,250	(215,104)
923980	Outside Services Employee &	(2,345)	(2,583)	238	(912)	(2,588)	1,676
924000	Property Insurance	138	176	(38)	(93)	(82)	(11)
924050	Inter-Co Prop Ins Exp	5,672	5,977	(305)	5,672	5,977	(305)
924980	Property Insurance For Corp.	4,961	4,605	356	4,961	4,605	356
925000	Injuries & Damages	2,914	20,682	(17,768)	4,149	7,522	(3,373)
925051	INTER-CO GEN LIAB EXP	20,325	22,825	(2,500)	20,325	22,825	(2,500)
925200	Injuries And Damages-Other	313	218	95	309	209	100
925300	Environmental Inj & Damages	0	0	0	144,493	1,659	142,834
925980	Injuries And Damages For Corp.	376	358	18	376	358	18
926000	EMPL PENSIONS AND BENEFITS	79,692	188,710	(109,018)	107,695	332,991	(225,296)
926430	Employees'Recreation Expense	0	0	0	0	1	(1)
926600	Employee Benefits-Transferred	61,142	93,765	(32,623)	55,392	25,485	29,907
926999	Non Serv Pension (ASU 2017-07)	0	0	0	0	0	0
928000	Regulatory Expenses (Go)	0	0	0	0	0	0
928006	State Reg Comm Proceeding	16,895	15,471	1,424	16,895	15,471	1,424
929000	Duplicate Chrgs-Enrgy To Exp	(289)	(58)	(231)	(65)	(56)	(9)
929500	Admin Exp Transf	(15,484)	(25,116)	9,632	(26,415)	(29,232)	2,817
930150	Miscellaneous Advertising Exp	348	411	(63)	836	130	706
930200	Misc General Expenses	5,533	1,258	4,275	124,464	20,202	104,262
930210	Industry Association Dues	96	0	96	0	0	0
930220	Exp Of Servicing Securities	(42)	0	(42)	148	(50)	198
930230	Dues To Various Organizations	0	0	0	2,340	84	2,255
930240	Director'S Expenses	277	621	(344)	266	366	(100)
930250	Buy\Sell Transf Employee Homes	325	1,149	(824)	1,903	819	1,084
930700	Research & Development	250	295	(45)	45	105	(61)
930940	General Expenses	75	80	(5)	38	57	(19)
931001	Rents-A&G	25,392	5,658	19,734	27,335	6,168	21,167
931008	A&G Rents-IC	21,697	19,088	2,609	21,533	20,265	1,268
932000	Maintenance Of Gen Plant-Gas	0	0	0	1,774	1,097	677
935100	Maint General Plant-Elec	83	(361)	444	(1,771)	559	(2,330)
935200	Cust Infor & Computer Control	73	226	(153)	(21)	18	(39)

		October			November		
Account	Description	2016	2017	Variance	2016	2017	Variance
403002	Depr-Expense	932,924	975,267	(42,343)	936,615	979,732	(43,117)
403150	Depreciation Expense - ARO	0	0	0	0	0	0
404200	Amort Of Elec Plt - Software	56,789	146,045	(89,256)	77,132	147,869	(70,737)
407355	DSM Deferral - Gas	15,939	(88,959)	104,898	143,072	(140,167)	283,239
408121	Taxes Property-Operating	307,157	227,667	79,500	721,368	227,667	493,701
408150	State Unemployment Tax	(617)	62	(679)	55	35	20
408151	Federal Unemployment Tax	25	336	(311)	31	326	(295)
408152	Employer FICA Tax	29,055	29,748	(693)	24,110	30,473	(6,363)
408205	Highway Use Tax	44	9	35	272	0	272
408470	Franchise Tax	0	1,150	(1,150)	3,933	0	3,933
408700	Fed Social Security Tax-Elec	1,000	0	1,000	1,000	0	1,000
408800	Federal Highway Use Tax-Elec	0	2	(2)	2	0	2
408851	Sales & Use Tax Exp	0	0	0	1	0	1
408960	Allocated Payroll Taxes	13,653	11,420	2,233	23,009	27,141	(4,132)
409102	Sit Exp-Utility	21,017	(57,874)	78,891	87,377	81,739	5,638
409104	Current State Income Tax - PY	(190,517)	25,557	(216,074)	0	0	0
409190	Federal Income Tax-Electric-CY	90,316	(785,229)	875,545	672,995	89,247	583,748
409191	Fed Income Tax-Electric-PY	0	179,863	(179,863)	0	0	0
409195	UTP Tax Expense: Fed Util-PY	0	0	0	0	0	0
410100	DFIT: Utility: Current Year	793,104	1,087,301	(294,197)	515,986	1,063,891	(547,905)
410102	DSIT: Utility: Current Year	49,996	164,122	(114,126)	551,411	245,138	306,273
410105	DFIT: Utility: Prior Year	(325)	(160,235)	159,910	0	24,596	(24,596)
410106	DSIT: Utility: Prior Year	185,156	(18,870)	204,026	0	0	0
411050	Accretion Expense ARO	0	0	0	0	0	0
411100	DFIT: Utility: Curr Year CR	(688,325)	(352,638)	(535,687)	(1,255,101)	(1,913,675)	658,574
411101	DSIT: Utility: Curr Year CR	(165,452)	(120,225)	(45,227)	(101,689)	(458,877)	357,188
411102	DFIT: Utility: Prior Year CR	(64,480)	12,473	(76,953)	0	(33,384)	33,384
411103	DSIT: Utility: Prior Year CR	0	(25,698)	25,698	0	(30,868)	30,868
426510	Other	16,442	0	16,442	(134,271)	0	(134,271)
426891	IC Sale of AR Fees VIE	9,173	9,150	23	9,115	9,586	(471)
711000	Gas Boiler Labor	2	19	(17)	34	48	(14)
712000	Gas Production-Other Power Ex	116	8	108	363	104	259
717000	Liq Petro Gas Exp-Vapor Proc	7,540	11,179	(3,639)	20,449	12,802	7,647
728000	Liquid Petroleum Gas	0	0	0	0	0	0
736000	Gas Misc Production Exp	3,275	1,705	1,570	(2,082)	672	(2,754)
742000	Maint Gas Production Equipmen	648	5,898	(5,250)	17,321	3,393	13,928
801000	Purchases Gas & NGL	1,377,320	1,486,592	(109,272)	2,984,586	4,053,973	(1,069,387)
801001	Purchases Gas & NGL-Aff	4,489	158,685	(154,196)	37,321	162,900	(125,579)
805002	Unrecovered Purchase Gas Adj	(486,759)	(851,402)	364,643	(1,203,637)	(1,535,378)	331,741
805003	Purchase Gas Cost Unbilled Rev	324,253	727,870	(403,617)	1,458,201	1,382,280	75,921
807000	Gas Purchased Expenses	27,433	30,659	(3,226)	34,931	29,413	5,518
807100	I/C Gas Purchased Expenses	2,270	1,193	1,077	304	576	(272)
813001	Other Gas Supply Expenses	39,930	34,248	5,682	51,642	40,588	11,054
850001	Operation Supv & Eng-Tran	0	0	0	0	0	0
870000	Distribution Sys Ops-Supv/Eng	(2,152)	0	(2,152)	0	0	0
871000	Distribution Load Dispatching	13,371	13,017	354	16,126	11,403	4,723
874000	Mains And Services	237,942	260,164	(22,222)	237,898	243,065	(5,167)
875000	Measuring And Reg Stations-Ge	987	11	976	3,250	10	3,240
876000	Measuring & Reg Station-Indus	4,244	874	3,370	3,541	302	3,239
878000	Meter And House Regulator Exp	200,381	125,100	75,281	53,928	133,247	(79,319)
879000	Customer Installation Expense	35,479	85,915	(50,436)	73,182	90,690	(17,508)
880000	Gas Distribution-Other Expense	223,979	162,779	61,200	187,349	176,245	11,104
885000	Maintenance Dist. System Fac - Supv / Eng	(3,819)	0	(3,819)	0	0	0
887000	Maintenance of Mains	78,954	141,676	(62,722)	113,656	88,063	25,592
889000	Maint-Meas/Reg Stn Equip-Gas	6,218	2,146	4,072	6,451	5,105	1,346
892000	Maintenance of Services	48,169	55,121	(6,952)	11,794	33,343	(21,549)
893000	Maint - Meters And House Reg	25,153	19,294	5,859	43,484	21,992	21,492
894000	Maint-Other Distribution Equip	8,470	5,152	3,318	1,785	(13,835)	15,620
901000	Supervision-Cust Accts	32,971	42,175	(9,204)	41,818	30,415	11,403
902000	Meter Reading Expense	40,489	36,411	4,078	34,914	24,441	10,473
903000	Cust Records & Collection Exp	174,155	217,340	(43,185)	152,661	15,307	137,354
903100	Cust Contracts & Orders-Local	7,882	9,122	(1,240)	11,209	10,515	694
903200	Cust Billing & Acct	133,003	52,140	80,863	137,477	52,053	85,424
903250	Customer Billing-Common	80,681	0	80,681	150,444	0	150,444
903300	Cust Collecting-Local	9,834	11,500	(1,666)	9,675	11,731	(2,056)
903400	Cust Receiv & Collect Exp-Edp	1,924	3,013	(1,089)	2,037	2,120	(83)
903891	IC Collection Agent Revenue	0	(2,951)	2,951	0	(3,580)	3,580
904001	BAD DEBT EXPENSE	(80,913)	0	(80,913)	11,165	0	11,165
904003	Cust Acctg-Loss On Sale-A/R	0	0	0	0	0	0
904891	IC Loss on Sale of AR VIE	(3,135)	0	(3,135)	(11,165)	0	(11,165)
905000	Misc Customer Accts Expenses	69	31	38	0	5	(5)
908000	Cust Asst Exp-Conservation Pro	0	0	0	0	0	0
908150	Commer/Indust Assistance Exp	0	0	0	0	0	0
908160	Cust Assist Exp-General	13,284	10,458	2,826	14,409	10,784	3,625
909650	Misc Advertising Expenses	0	782	(782)	64	0	64
910000	Misc Cust Serv/Inform Exp	15,665	13,155	2,510	16,381	18,302	(1,921)
910100	Exp-Rs Reg Prod/Svces-CstAccts	6,977	5,737	1,240	19,442	13,094	6,348
911000	Supervision	0	0	0	0	0	0
912000	Demonstrating & Selling Exp	4,997	10,835	(5,838)	22,108	16,046	6,062
913001	Advertising Expense	4	1,566	(1,562)	2,492	2,123	369
920000	A & G Salaries	125,926	148,187	(22,261)	128,274	176,321	(48,047)
921100	Employee Expenses	20,978	(6,575)	27,553	(3,901)	6,103	(10,004)
921101	Employee Exp - NC	0	0	0	0	0	0
921110	Relocation Expenses	46	162	(116)	10	0	10
921200	Office Expenses	9,737	14,808	(5,071)	12,316	26,528	(14,212)
921300	Telephone And Telegraph Exp	3	5	(2)	8	3	5
921400	Computer Services Expenses	18,936	15,699	3,237	15,095	8,425	6,670
921540	Computer Rent (Go Only)	7,093	10,100	(3,007)	6,691	12,016	(5,325)
921600	Other	44	161	(117)	52	20	32
921980	Office Supplies & Expenses	33,597	88,015	(54,418)	30,043	50,881	(20,838)
922000	Admin Exp Transfer	1	0	1	0	0	0
923000	Outside Services Employed	44,754	109,127	(64,373)	46,366	120,683	(74,317)
923980	Outside Services Employee &	(3,755)	(2,034)	(1,721)	(1,993)	(1,722)	(271)
924000	Property Insurance	138	108	30	200	137	63
924050	Inter-Co Prop Ins Exp	5,672	5,977	(305)	5,672	5,977	(305)
924980	Property Insurance For Corp.	4,961	4,605	356	4,951	4,605	356
925000	Injuries & Damages	3,423	5,743	(2,320)	3,405	4,990	(1,585)
925051	INTER-CO GEN LIAB EXP	20,325	22,825	(2,500)	20,325	22,825	(2,500)
925200	Injuries And Damages-Other	320	232	88	303	183	120
925300	Environmental Inj & Damages	0	0	0	0	0	0
925980	Injuries And Damages For Corp.	376	358	18	376	358	18
926000	EMPL PENSIONS AND BENEFITS	96,733	(92,553)	189,286	100,681	(55,461)	156,142
926430	Employees'Recreation Expense	0	0	0	1	0	1
926600	Employee Benefits-Transferred	45,679	17,487	28,192	82,828	(18,396)	101,224
926999	Non Serv Pension (ASU 2017-07)	0	0	0	0	0	0
928000	Regulatory Expenses (Go)	16	0	16	0	0	0
928006	State Reg Comm Proceeding	16,895	15,471	1,424	16,895	15,471	1,424
929000	Duplicate Chrgs-Enrgy To Exp	(66)	(158)	92	(224)	(285)	61
929500	Admin Exp Transf	(22,742)	(25,382)	2,640	(41,137)	(18,402)	(22,735)
930150	Miscellaneous Advertising Exp	542	439	103	545	723	(178)
930200	Misc General Expenses	(82)	53,540	(53,622)	10,145	6,700	3,445
930210	Industry Association Dues	0	0	0	0	0	0
930220	Exp Of Servicing Securities	(189)	(19)	(170)	(15)	6	(21)
930230	Dues To Various Organizations	3,189	2,457	732	5,058	1,973	3,085
930240	Director'S Expenses	1,918	1,614	304	110	128	(18)
930250	Buy\Sell Transf Employee Homes	379	435	(56)	364	209	155
930700	Research & Development	154	82	72	516	175	341
930940	General Expenses	21	7	14	9	72	(63)
931001	Rents-A&G	18,777	63,695	(44,918)	17,560	6,512	11,048
931006	A&G Rents-IC	21,847	19,047	2,800	21,853	21,064	789
932000	Maintenance Of Gen Plant-Gas	0	0	0	0	0	0
935100	Maint General Plant-Elec	528	331	197	1,570	35	1,535
935200	Cust Infor & Computer Control	414	21	393	98	42	56

		December			January		
Account	Description	2016	2017	Variance	2,017	2018	Variance
403002	Depr-Expense	949,978	986,181	(36,203)	943,703	986,218	(42,515)
403150	Depreciation Expense - ARO	0	0	0	0	6,282	(6,282)
404200	Amort Of Elec Plt - Software	117,174	147,348	(30,172)	90,098	147,251	(57,153)
407355	DSM Deferral - Gas	433,374	561,463	(128,089)	435,096	(233,576)	668,672
408121	Taxes Property-Operating	308,477	227,667	80,810	227,803	242,250	(14,447)
408150	State Unemployment Tax	112	33	79	4,187	3,915	272
408151	Federal Unemployment Tax	51	334	(283)	1,488	1,728	(240)
408152	Employer FICA Tax	25,172	27,658	(2,486)	29,766	33,103	(3,337)
408205	Highway Use Tax	0	0	0	9	258	(249)
408470	Franchise Tax	8,437	0	8,437	0	0	0
408700	Fed Social Security Tax-Elec	5,000	7,000	(2,000)	0	0	0
408800	Federal Highway Use Tax-Elec	0	0	0	1	0	1
408851	Sales & Use Tax Exp	1	0	1	0	(2)	2
408960	Allocated Payroll Taxes	53,616	69,852	(16,236)	64,364	47,280	17,084
409102	St Exp-Utility	261,167	185,860	75,307	0	0	0
409104	Current State Income Tax - PY	0	258,385	(258,385)	0	0	0
409190	Federal Income Tax-Electric-CY	1,515,498	3,321,651	(1,805,153)	0	0	0
409191	Fed Income Tax-Electric-PY	0	1,609,679	(1,609,679)	0	0	0
409195	UTP Tax Expense: Fed Util-PY	0	0	0	0	0	0
410100	DFIT: Utility: Current Year	426,218	(1,460,934)	1,887,152	0	0	0
410102	DSIT: Utility: Current Year	152,680	(130,247)	282,927	0	0	0
410105	DFIT: Utility: Prior Year	0	246,813	(246,813)	0	0	0
410106	DSIT: Utility: Prior Year	0	39,822	(39,822)	0	0	0
411050	Accretion Expense ARO	0	0	0	0	161	(161)
411100	DFIT: Utility: Curr Year CR	(747,256)	829,332	(1,576,588)	0	0	0
411101	DSIT: Utility: Curr Year CR	(200,989)	385,523	(586,512)	0	0	0
411102	DFIT: Utility: Prior Year CR	0	(1,770,452)	1,770,452	0	0	0
411103	DSIT: Utility: Prior Year CR	0	(285,652)	285,652	0	0	0
426510	Other	(328,188)	0	(328,188)	0	0	0
426891	IC Sale of AR Fees VIE	10,086	10,568	(482)	9,885	13,129	(3,244)
711000	Gas Boiler Labor	473	407	66	1,884	828	1,056
712000	Gas Production-Other Power Ex	358	10,621	(10,263)	2,144	825	1,319
717000	Liq Petro Gas Exp-Vapor Proc	13,130	9,373	3,757	6,218	5,164	1,054
728000	Liquid Petroleum Gas	164,510	382,448	(217,938)	206,504	1,281,656	(1,075,152)
735000	Gas Misc Production Exp	3,197	3,128	69	12,125	22,325	(10,200)
742000	Maint Gas Production Equipmen	10,092	18,522	(8,430)	12,155	21,371	(9,216)
801000	Purchases Gas & NGL	5,821,691	7,380,817	(559,126)	6,955,656	8,676,252	(1,720,594)
801001	Purchases Gas & NGL-Aff	52,123	174,141	(122,018)	50,927	179,009	(128,082)
805002	Unrecovered Purchase Gas Adj	(1,526,521)	(2,127,234)	600,613	2,002,075	(505,587)	2,507,662
805003	Purchase Gas Cost Unbilled Rev	2,306,471	1,746,593	562,878	(1,356,963)	(959,758)	(397,205)
807000	Gas Purchased Expenses	16,858	30,966	(14,108)	43,771	70,455	(26,684)
807100	I/C Gas Purchased Expenses	3,288	1,034	2,254	4,818	5,053	(235)
813001	Other Gas Supply Expenses	44,753	42,857	1,896	37,798	23,687	14,111
850001	Operation Supv & Eng-Tran	0	0	0	0	0	0
870000	Distribution Sys Ops-Supv/Eng	0	0	0	0	0	0
871000	Distribution Load Dispatching	15,826	11,641	4,185	14,091	12,759	1,332
874000	Mains And Services	135,821	155,233	(29,412)	227,549	140,492	87,057
875000	Measuring And Reg Stations-Ge	62,027	11	62,016	10	10	0
876000	Measuring & Reg Station-Indus	2,689	1,856	833	2,084	129	1,955
878000	Meter And House Regulator Exp	162,636	244,899	(82,263)	201,470	64,033	137,437
879000	Customer Installation Expense	224,818	85,180	139,638	191,128	127,001	64,127
880000	Gas Distribution-Other Expense	282,518	188,819	93,699	205,231	166,621	38,610
885000	Maintenance Dist. System Fac - Supv / Eng	0	0	0	0	0	0
887000	Maintenance of Mains	118,333	73,442	44,891	69,960	109,971	(40,011)
889000	Maint-Meas/Reg Stn Equip-Gas	2,528	3,548	(1,020)	2,343	314	2,029
892000	Maintenance of Services	80,701	109,962	(49,261)	29,703	7,046	22,657
893000	Maint - Meters And House Reg	82,100	35,205	46,895	20,325	44,902	(24,577)
894000	Maint-Other Distribution Equip	5,928	(46,691)	52,619	(8,357)	(7,168)	(1,189)
901000	Supervision-Cust Accts	45,963	61,958	(15,995)	48,743	45,049	3,694
902000	Meter Reading Expense	37,367	35,301	2,066	45,155	28,767	16,388
903000	Cust Records & Collection Exp	61,699	94,661	(32,962)	162,718	268,404	(105,686)
903100	Cust Contracts & Orders-Local	18,741	15,089	3,652	28,864	6,912	21,952
903200	Cust Billing & Acct	49,834	52,646	(2,812)	45,550	58,631	(13,081)
903250	Customer Billing-Common	46,951	0	46,951	0	0	0
903300	Cust Collecting-Local	11,358	12,626	(1,268)	9,215	8,900	315
903400	Cust Receiv & Collect Exp-Edp	3,599	2,457	1,142	2,186	2,293	(107)
903891	IC Collection Agent Revenue	(52,261)	(4,482)	(47,779)	(4,350)	(5,074)	724
904001	BAD DEBT EXPENSE	(36,108)	(398)	(35,710)	6,047	4,427	1,620
904003	Cust Acctg-Loss On Sale-A/R	0	0	0	0	0	0
904891	IC Loss on Sale of AR VIE	292,376	0	292,376	0	0	0
905000	Misc Customer Accts Expenses	44	23	21	22	0	22
908000	Cust Asst Exp-Conservation Pro	1	0	1	0	3	(3)
908150	Commer/Indust Assistance Exp	0	0	0	0	0	0
908160	Cust Assist Exp-General	12,549	9,828	2,721	12,570	13,638	(1,068)
909650	Misc Advertising Expenses	133	0	133	0	437	(437)
910000	Misc Cust Serv/Inform Exp	19,138	22,954	(3,815)	20,123	13,229	6,894
910100	Exp-Rs Reg Prod/Svces-CstAccts	2,495	16,178	(13,683)	2,616	13,415	(10,799)
911000	Supervision	0	19	(19)	0	0	0
912000	Demonstrating & Selling Exp	11,467	7,489	3,978	11,238	8,361	2,877
913001	Advertising Expense	287	1,747	(1,460)	156	0	156
920000	A & G Salaries	384,156	183,697	200,461	114,959	171,446	(56,477)
921100	Employee Expenses	(2,468)	3,077	(5,545)	16,191	14,947	1,244
921101	Employee Exp - NC	0	0	0	0	2	(2)
921110	Relocation Expenses	352	5	347	320	373	(53)
921200	Office Expenses	17,743	34,661	(16,918)	10,159	1,661	8,498
921300	Telephone And Telegraph Exp	7	0	7	1	2	(1)
921400	Computer Services Expenses	21,491	20,048	1,443	17,655	7,492	10,163
921540	Computer Rent (Go Only)	6,045	14,006	(7,961)	6,081	16,397	(10,316)
921600	Other	52	11	41	10	126	(116)
921980	Office Supplies & Expenses	38,076	37,765	311	27,315	30,742	(3,427)
922000	Admin Exp Transfer	0	287	(287)	43	0	43
923000	Outside Services Employed	102,870	103,816	(946)	27,823	69,415	(41,592)
923980	Outside Services Employee &	(384)	660	(1,044)	(1,067)	(1,641)	574
924000	Property Insurance	(163)	(82)	(81)	137	19	118
924050	Inter-Co Prop Ins Exp	5,672	5,977	(305)	5,977	292	5,685
924980	Property Insurance For Corp.	4,961	4,605	356	4,605	4,390	215
925000	Injuries & Damages	4,839	6,826	(1,987)	7,531	1,471	6,160
925051	INTER-CO GEN LIAB EXP	20,325	22,825	(2,500)	22,825	5,100	17,725
925200	Injuries And Damages-Other	314	170	144	205	190	15
925300	Environmental Inj & Damages	2,469	439	2,030	0	0	0
925980	Injuries And Damages For Corp.	376	358	18	358	363	(5)
926000	EMPL PENSIONS AND BENEFITS	(24,705)	605,558	(630,263)	98,225	138,845	(40,620)
926430	Employees'Recreation Expense	14	23	(9)	0	0	0
926600	Employee Benefits-Transferred	36,596	164,772	(128,176)	91,653	119,296	(27,643)
926999	Non Serv Pension (ASU 2017-07)	0	0	0	0	260	(260)
928000	Regulatory Expenses (Go)	0	0	0	0	0	0
928006	State Reg Comm Proceeding	16,895	15,471	1,424	16,895	15,471	1,424
929000	Duplicate Chrgs-Enrgy To Exp	(1,338)	(4,156)	2,818	(10,878)	(7,693)	(3,185)
929500	Admin Exp Transf	(23,375)	(15,871)	(7,504)	(11,484)	(10,299)	(1,185)
930150	Miscellaneous Advertising Exp	525	2,504	(1,979)	578	(814)	1,392
930200	Misc General Expenses	13,586	5,226	8,340	54	108,492	(108,438)
930210	Industry Association Dues	0	0	0	25,917	19,308	6,609
930220	Exp Of Servicing Securities	(14)	(23)	9	0	(9)	9
930230	Dues To Various Organizations	6,125	4,670	1,455	256	1,923	(1,667)
930240	Director'S Expenses	2,383	1,972	411	2,435	2,066	369
930250	Buy\Sell Transf Employee Homes	826	588	238	757	306	451
930700	Research & Development	175	367	(192)	12	143	(131)
930940	General Expenses	73	97	(24)	38	51	(13)
931001	Rents-A&G	41,053	5,868	35,185	18,415	5,603	12,812
931006	A&G Rents-IC	25,271	20,943	4,328	28,648	26,072	2,576
932000	Maintenance Of Gen Plant-Gas	2,923	502	2,421	0	0	0
935100	Maint General Plant-Elec	(2,097)	(366)	(1,731)	(114)	(766)	652
935200	Cust Infor & Computer Control	119	43	76	72	1	71

		February			March		
Account	Description	2,017	2018	Variance	2,017	2018	Variance
403002	Depr-Expense	948,241	997,759	(49,518)	951,895	1,027,026	(75,131)
403150	Depreciation Expense - ARO	0	6,282	(6,282)	0	(12,564)	12,564
404200	Amort Of Elec Plt - Software	90,397	154,931	(64,534)	91,860	148,629	(58,769)
407355	DSM Deferral - Gas	293,522	(329,245)	628,767	216,028	(355,219)	571,247
408121	Taxes Property-Operating	227,667	242,250	(14,583)	227,667	242,250	(14,583)
408150	State Unemployment Tax	813	771	42	(1,806)	(2,341)	535
408151	Federal Unemployment Tax	(166)	(50)	(118)	(249)	(278)	29
408152	Employer FICA Tax	25,426	32,164	(6,738)	34,677	45,161	(10,484)
408205	Highway Use Tax	0	0	0	0	0	0
408470	Franchise Tax	0	0	0	1,158	1,318	(160)
408700	Fed Social Security Tax-Elec	0	0	0	(7,000)	(7,000)	0
408800	Federal Highway Use Tax-Elec	0	1	(1)	0	0	0
408851	Sales & Use Tax Exp	0	(243)	243	0	0	0
408960	Allocated Payroll Taxes	29,270	24,094	5,176	(47,036)	(7,821)	(39,215)
409102	Sit Exp-Utility	687,447	344,565	342,882	(202,279)	100,907	(303,186)
409104	Current State Income Tax - PY	0	0	0	0	0	0
409190	Federal Income Tax-Electric-CY	3,573,224	1,413,098	2,160,126	(1,597,471)	441,124	(2,038,595)
409191	Fed Income Tax-Electric-PY	0	0	0	0	0	0
409195	UTP Tax Expense: Fed Util-PY	0	0	0	0	0	0
410100	DFIT: Utility: Current Year	1,307,130	1,157,120	150,010	4,711,096	565,438	4,145,658
410102	DSIT: Utility: Current Year	193,878	344,691	(150,813)	749,434	168,817	580,617
410105	DFIT: Utility: Prior Year	0	0	0	0	0	0
410106	DSIT: Utility: Prior Year	0	0	0	0	0	0
411050	Accretion Expense ARO	0	161	(161)	0	(322)	322
411100	DFIT: Utility: Curr Year CR	(2,561,999)	(861,296)	(1,700,703)	(2,501,136)	(463,601)	(2,037,535)
411101	DSIT: Utility: Curr Year CR	(517,541)	(244,367)	(273,174)	(455,632)	(131,045)	(324,587)
411102	DFIT: Utility: Prior Year CR	0	0	0	0	0	0
411103	DSIT: Utility: Prior Year CR	0	0	0	0	0	0
426510	Other	0	0	0	0	0	0
426891	IC Sale of AR Fees VIE	10,429	14,836	(4,407)	9,477	13,448	(3,971)
711000	Gas Boiler Labor	2,066	6,066	(4,000)	0	498	(498)
712000	Gas Production-Other Power Ex	3,112	0	3,112	10,927	1,042	9,885
717000	Liq Petro Gas Exp-Vapor Proc	9,476	5,467	4,009	12,812	8,402	4,410
728000	Liquid Petroleum Gas	0	0	0	0	0	0
735000	Gas Misc Production Exp	1,185	10,713	(9,528)	2,081	14,193	(12,112)
742000	Maint Gas Production Equipmen	2,258	5,900	(3,642)	1,421	3,226	(1,805)
801000	Purchases Gas & NGL	4,305,631	5,531,090	(1,225,459)	4,116,570	3,653,116	463,454
801001	Purchases Gas & NGL-Aff	205,059	174,298	30,761	203,337	169,936	33,401
805002	Unrecovered Purchase Gas Adj	1,515,541	1,626,044	(110,503)	1,013,072	1,296,841	(283,769)
805003	Purchase Gas Cost Unbilled Rev	(189,218)	(950,929)	761,711	(513,133)	125,397	(738,530)
807000	Gas Purchased Expenses	33,127	80,390	(47,263)	21,000	73,845	(52,845)
807100	I/C Gas Purchased Expenses	6,999	3,146	3,853	8,172	1,433	6,739
813001	Other Gas Supply Expenses	46,211	96,461	(50,250)	52,506	(18,736)	71,242
850001	Operation Supv & Eng-Tran	0	0	0	0	0	0
870000	Distribution Sys Ops-Supv/Eng	0	0	0	0	0	0
871000	Distribution Load Dispatching	14,142	11,808	2,334	14,382	12,416	1,966
874000	Mains And Services	211,099	160,380	50,719	235,086	126,225	108,861
875000	Measuring And Reg Stations-Ge	18	4,525	(4,507)	11	425	(414)
876000	Measuring & Reg Station-Indus	1,704	0	1,704	1,931	1,091	840
878000	Meter And House Regulator Exp	79,521	35,615	43,906	248,516	33,373	215,143
879000	Customer Installation Expense	138,796	140,935	(2,139)	163,683	108,167	55,516
880000	Gas Distribution-Other Expense	176,038	121,759	54,279	188,008	192,018	(4,010)
885000	Maintenance Dist. System Fac - Supv / Eng	0	0	0	0	0	0
887000	Maintenance of Mains	70,493	92,696	(22,203)	87,809	264,147	(176,338)
889000	Maint-Meas/Reg Stn Equip-Gas	4,443	1,670	2,773	3,471	4,869	(1,398)
892000	Maintenance of Services	22,602	3,374	19,228	207,194	16,258	190,936
893000	Maint - Meters And House Reg	17,353	17,293	60	30,316	30,061	255
894000	Maint-Other Distribution Equip	8,766	(14,731)	23,497	(7,078)	(7,724)	646
901000	Supervision-Cust Accts	43,614	42,255	1,359	57,932	36,449	21,483
902000	Meter Reading Expense	35,979	39,983	(4,004)	69,753	32,366	37,387
903000	Cust Records & Collection Exp	136,536	52,240	84,299	164,458	151,571	12,887
903100	Cust Contracts & Orders-Local	4,540	10,221	(5,681)	13,543	29,270	(15,727)
903200	Cust Billing & Acct	133,051	132,827	224	59,103	80,200	(21,097)
903250	Customer Billing-Common	0	0	0	0	0	0
903300	Cust Collecting-Local	10,888	10,373	515	12,642	25,158	(12,516)
903400	Cust Receiv & Collect Exp-Edp	1,955	2,070	(114)	2,102	2,205	(103)
903891	IC Collection Agent Revenue	(3,705)	(4,344)	639	(3,508)	(3,924)	416
904001	BAD DEBT EXPENSE	(7,828)	0	(7,828)	6,693	0	6,693
904003	Cust Acctg-Loss On Sale-A/R	0	0	0	0	0	0
904891	IC Loss on Sale of AR VIE	0	0	0	0	0	0
905000	Misc Customer Accts Expenses	14	21	(7)	10	39	(29)
908000	Cust Asst Exp-Conservation Pro	0	0	0	0	2	(2)
908150	Commer/Indust Assistance Exp	0	0	0	0	0	0
908160	Cust Assist Exp-General	12,823	12,948	(125)	12,328	13,588	(1,240)
909650	Misc Advertising Expenses	0	138	(138)	211	0	211
910000	Misc Cust Serv/Inform Exp	27,430	13,933	13,497	10,457	14,932	(4,475)
910100	Exp-Rs Reg Prod/Svces-CstAccts	23,564	3,512	20,052	17,929	1,185	16,744
911000	Supervision	0	26	(26)	0	45	(45)
912000	Demonstrating & Selling Exp	7,809	10,759	(2,950)	8,733	8,901	(168)
913001	Advertising Expense	0	522	(522)	170	1,660	(1,490)
920000	A & G Salaries	121,493	171,899	(50,406)	65,228	124,597	(59,369)
921100	Employee Expenses	12,004	25,712	(13,708)	10,603	12,216	(1,613)
921101	Employee Exp - NC	0	0	0	0	0	0
921110	Relocation Expenses	13	0	13	220	7	213
921200	Office Expenses	17,197	17,304	(107)	8,614	(32,916)	41,530
921300	Telephone And Telegraph Exp	4	0	4	21	3	18
921400	Computer Services Expenses	25,729	13,664	12,065	20,632	65,269	(44,637)
921540	Computer Rent (Go Only)	6,404	16,270	(9,866)	6,252	15,624	(9,372)
921600	Other	10	51	(41)	14	187	(173)
921980	Office Supplies & Expenses	27,969	34,496	(6,527)	30,460	39,228	(8,768)
922000	Admin. Exp Transfer	0	0	0	0	0	0
923000	Outside Services Employed	55,435	120,884	(65,449)	82,941	138,779	(55,838)
923980	Outside Services Employee &	(887)	(1,461)	574	(2,796)	2,581	(5,377)
924000	Property Insurance	123	80	43	(21)	(78)	57
924050	Inter-Co Prop Ins Exp	5,977	292	5,685	5,977	292	5,685
924980	Property Insurance For Corp.	4,605	4,390	215	4,605	4,390	215
925000	Injuries & Damages	5,065	1,475	3,590	6,684	1,506	5,178
925051	INTER-CO GEN LIAB EXP	22,825	5,100	17,725	22,825	5,100	17,725
925200	Injuries And Damages-Other	197	217	(20)	225	187	38
925300	Environmental Inj & Damages	0	0	0	301	13,568	(13,267)
925980	Injuries And Damages For Corp.	358	363	(5)	358	363	(5)
926000	EMPL PENSIONS AND BENEFITS	116,884	125,944	(9,060)	190,611	150,300	40,311
926430	Employees'Recreation Expense	0	0	0	0	10	(10)
926600	Employee Benefits-Transferred	65,989	85,251	(19,262)	16,042	71,509	(55,467)
926999	Non Serv Pension (ASU 2017-07)	0	(44,678)	44,678	0	(22,208)	22,208
928000	Regulatory Expenses (Go)	0	0	0	0	0	0
928006	State Reg Comm Proceeding	16,895	15,471	1,424	16,895	15,471	1,424
929000	Duplicate Chrgs-Enrgy To Exp	(12,250)	(24,497)	12,247	(4,701)	(6,867)	2,166
929500	Admin Exp Transf	(14,181)	(17,912)	3,731	(13,067)	(17,369)	4,302
930150	Miscellaneous Advertising Exp	627	462	165	369	7,742	(7,373)
930200	Misc General Expenses	(858)	(11,175)	10,317	63,075	38,363	24,712
930210	Industry Association Dues	0	0	0	(3,934)	21	(3,955)
930220	Exp Of Servicing Securities	0	(20)	20	13	(16)	29
930230	Dues To Various Organizations	21	8,209	(8,188)	291	175	116
930240	Director'S Expenses	4	81	(77)	167	203	(36)
930250	Buy\Sell Transf Employee Homes	31	131	(100)	1,153	595	558
930700	Research & Development	46	(278)	324	24	38	(14)
930940	General Expenses	173	171	2	11	(1)	12
931001	Rents-A&G	17,394	11,774	5,620	7,643	8,997	(1,354)
931008	A&G Rents-IC	28,466	18,525	9,941	31,244	22,333	8,911
932000	Maintenance Of Gen Plant-Gas	0	0	0	587	3,658	(3,071)
935100	Maint General Plant-Elec	(71)	28	(99)	185	738	(553)
935200	Cust Infor & Computer Control	(11)	136	(147)	(126)	845	(971)

		April			May		
Account	Description	2,017	2018	Variance	2,017	2018	Variance
403002	Depr-Expense	956,764	1,031,788	(75,024)	961,913	1,004,652	(42,739)
403150	Depreciation Expense - ARO	0	0	0	0	0	0
404200	Amort Of Elec Plt - Software	90,549	148,613	(58,064)	91,412	138,341	(46,929)
407355	DSM Deferral - Gas	(237,289)	(402,968)	165,679	(232,054)	(42,090)	(189,964)
408121	Taxes Property-Operating	227,667	249,945	(22,278)	227,667	242,250	(14,583)
408150	State Unemployment Tax	42	15	27	27	57	(30)
408151	Federal Unemployment Tax	320	327	(7)	323	369	(46)
408152	Employer FICA Tax	25,873	32,183	(6,310)	30,649	33,300	(2,651)
408205	Highway Use Tax	10	6	4	0	(24)	24
408470	Franchise Tax	0	0	0	772	879	(107)
408700	Fed Social Security Tax-Elec	0	0	0	0	0	0
408800	Federal Highway Use Tax-Elec	0	0	0	0	0	0
408851	Sales & Use Tax Exp	(86)	5	(71)	0	1	(1)
408960	Allocated Payroll Taxes	19,121	9,795	9,326	15,673	3,533	12,140
409102	Sit Exp-Utility	0	0	0	(81,033)	(83,959)	2,926
409104	Current State Income Tax - PY	0	0	0	0	0	0
409190	Federal Income Tax-Electric-CY	0	0	0	(1,189,760)	(72,791)	(1,116,969)
409191	Fed Income Tax-Electric-PY	0	0	0	0	0	0
409195	UTP Tax Expense: Fed Util-PY	0	0	0	0	0	0
410100	DFIT: Utility: Current Year	0	0	0	1,776,642	1,188,100	588,542
410102	DSIT: Utility: Current Year	0	0	0	265,305	66,921	198,384
410105	DFIT: Utility: Prior Year	0	0	0	0	0	0
410106	DSIT: Utility: Prior Year	0	0	0	0	0	0
411050	Accretion Expense ARO	0	0	0	0	0	0
411100	DFIT: Utility: Curr Year CR	0	0	0	(558,315)	(963,263)	404,948
411101	DSIT: Utility: Curr Year CR	0	0	0	(194,258)	1,409	(195,667)
411102	DFIT: Utility: Prior Year CR	0	0	0	0	0	0
411103	DSIT: Utility: Prior Year CR	0	0	0	0	0	0
426510	Other	0	0	0	0	0	0
426891	IC Sale of AR Fees VIE	9,941	15,205	(5,264)	9,096	15,508	(6,412)
711000	Gas Boiler Labor	959	447	512	177	288	(111)
712000	Gas Production-Other Power Ex	(10,067)	555	(10,622)	0	362	(362)
717000	Liq Petro Gas Exp-Vapor Proc	5,128	1,920	3,208	2,130	10,025	(7,895)
728000	Liquid Petroleum Gas	0	633	(633)	0	0	0
735000	Gas Misc Production Exp	2,926	564	2,362	2,322	193	2,129
742000	Maint Gas Production Equipmen	811	16,962	(16,151)	1,722	4,177	(2,455)
801000	Purchases Gas & NGL	1,311,519	3,024,295	(1,712,776)	1,279,714	1,325,330	(45,616)
801001	Purchases Gas & NGL-Aff	158,594	165,820	(7,226)	158,193	165,945	(7,752)
805002	Unrecovered Purchase Gas Adj	1,702,066	1,533,437	168,629	317,383	455,644	(138,261)
805003	Purchase Gas Cost Unbilled Rev	(960,611)	(994,550)	33,939	(651,938)	(988,490)	336,552
807000	Gas Purchased Expenses	33,147	35,524	(2,377)	38,480	34,806	3,674
807100	I/C Gas Purchased Expenses	6,303	690	5,613	4,054	1,009	3,045
813001	Other Gas Supply Expenses	71,993	15,140	56,853	68,018	4,484	63,534
850001	Operation Supv & Eng-Tran	0	0	0	0	0	0
870000	Distribution Sys Ops-Supv/Eng	0	0	0	0	0	0
871000	Distribution Load Dispatching	14,623	10,951	3,672	12,673	12,096	577
874000	Mains And Services	148,015	199,889	(51,874)	159,731	108,645	51,086
875000	Measuring And Reg Stations-Ge	861	49	812	10	1,362	(1,352)
876000	Measuring & Reg Station-Indus	911	0	911	5,102	1,464	3,638
878000	Meter And House Regulator Exp	35,972	47,594	(11,622)	496,530	18,199	478,331
879000	Customer Installation Expense	80,565	59,001	21,564	80,899	73,796	7,103
880000	Gas Distribution-Other Expense	74,086	113,930	(39,844)	433,663	82,649	351,014
885000	Maintenance Dist. System Fac - Supv / Eng	0	0	0	0	0	0
887000	Maintenance of Mains	38,778	175,126	(136,348)	79,217	133,953	(54,436)
889000	Maint-Meas/Reg Stn Equip-Gas	3,338	1,892	1,446	5,680	0	5,680
892000	Maintenance of Services	21,937	23,539	(1,602)	106,467	87,762	18,705
893000	Maint - Meters And House Reg	26,430	23,726	2,704	26,033	44,478	(18,445)
894000	Maint-Other Distribution Equip	(525)	2,054	(2,579)	(1,814)	(4,085)	2,271
901000	Supervision-Cust Accts	50,875	52,074	(1,199)	33,837	37,806	(3,969)
902000	Meter Reading Expense	39,491	25,221	14,270	35,850	36,830	(980)
903000	Cust Records & Collection Exp	103,986	188,525	(84,539)	159,940	172,513	(12,573)
903100	Cust Contracts & Orders-Local	9,271	8,672	599	11,205	8,522	2,683
903200	Cust Billing & Acct	49,693	49,451	242	48,606	61,230	(12,624)
903250	Customer Billing-Common	0	0	0	0	0	0
903300	Cust Collecting-Local	9,543	8,810	733	11,275	9,695	1,580
903400	Cust Receiv & Collect Exp-Edp	2,175	2,648	(473)	2,335	2,458	(123)
903891	IC Collection Agent Revenue	(2,856)	(3,670)	814	(2,834)	(3,585)	751
904001	BAD DEBT EXPENSE	(205)	3,159	(3,364)	(121)	525	(646)
904003	Cust Acctg-Loss On Sale-A/R	0	0	0	0	0	0
904891	IC Loss on Sale of AR VIE	0	0	0	0	0	0
905000	Misc Customer Accts Expenses	87	28	59	34	41	(7)
908000	Cust Asst Exp-Conservation Pro	0	0	0	0	3	(3)
908150	Commer/Indust Assistance Exp	0	0	0	0	0	0
908160	Cust Assist Exp-General	13,670	12,632	1,038	13,300	13,845	(545)
909650	Misc Advertising Expenses	0	0	0	0	0	0
910000	Misc Cust Serv/Inform Exp	8,913	15,496	(6,583)	22,432	15,432	7,000
910100	Exp-Rs Reg Prod/Svces-CstAccts	7,070	7,173	(103)	4,527	3,954	573
911000	Supervision	0	73	(73)	0	0	0
912000	Demonstrating & Selling Exp	9,538	10,479	(941)	(4,223)	15,954	(20,177)
913001	Advertising Expense	128	500	(372)	215	989	(774)
920000	A & G Salaries	180,138	189,432	(9,294)	159,516	188,496	(28,980)
921100	Employee Expenses	11,858	8,722	2,936	6,620	10,380	(3,760)
921101	Employee Exp - NC	0	0	0	0	12	(12)
921110	Relocation Expenses	0	0	0	0	0	0
921200	Office Expenses	15,596	77,040	(61,444)	20,067	10,062	10,005
921300	Telephone And Telegraph Exp	12	2	10	9	5	4
921400	Computer Services Expenses	5,711	(25,545)	31,256	6,582	19,697	(13,115)
921540	Computer Rent (Go Only)	5,985	15,127	(9,142)	7,497	13,097	(5,600)
921800	Other	54	16	38	75	86	(11)
921950	Office Supplies & Expenses	27,981	33,288	(5,307)	27,768	51,264	(23,496)
922000	Admin Exp Transfer	0	0	0	0	0	0
923000	Outside Services Employed	80,757	81,423	(666)	91,025	158,852	(67,827)
923980	Outside Services Employee &	(1,526)	(3,303)	1,777	(2,918)	2,365	(5,283)
924000	Property Insurance	137	48	89	(79)	1	(80)
924050	Inter-Co Prop Ins Exp	5,977	292	5,685	5,977	292	5,685
924980	Property Insurance For Corp.	4,605	4,390	215	4,605	4,390	215
925000	Injuries & Damages	7,941	907	7,034	5,887	1,183	4,704
925051	INTER-CO GEN LIAB EXP	22,825	5,100	17,725	22,825	5,100	17,725
925200	Injuries And Damages-Other	213	223	(10)	220	227	(7)
925300	Environmental Inj & Damages	0	0	0	0	0	0
925980	Injuries And Damages For Corp.	358	363	(5)	358	363	(5)
926000	EMPL PENSIONS AND BENEFITS	(13,792)	136,036	(149,828)	105,684	126,568	(20,884)
926430	Employees'Recreation Expense	0	0	0	0	31	(31)
926600	Employee Benefits-Transferred	42,651	52,264	(9,613)	19,054	63,894	(44,840)
926999	Non Serv Pension (ASU 2017-07)	0	(38,064)	38,064	0	(26,172)	26,172
928000	Regulatory Expenses (Go)	0	0	0	0	0	0
928005	State Reg Comm Proceeding	16,895	15,471	1,424	16,895	15,471	1,424
929000	Duplicate Chrgs-Enrgy To Exp	(5,925)	(5,679)	(246)	(1,592)	(3,182)	1,590
929500	Admin Exp Transf	(10,161)	(12,376)	2,215	(28,248)	(16,312)	(11,936)
930150	Miscellaneous Advertising Exp	737	2,801	(2,064)	1,351	2,654	(1,303)
930200	Misc General Expenses	(557)	11,534	(12,091)	657	(8,391)	9,048
930210	Industry Association Dues	0	0	0	0	0	0
930220	Exp Of Servicing Securities	0	(17)	17	2	243	(241)
930230	Dues To Various Organizations	1,070	0	1,070	12	(81)	93
930240	Director'S Expenses	1,758	1,618	140	7,695	7,632	63
930250	Buy/Sell Transf Employee Homes	239	116	123	248	(86)	334
930700	Research & Development	54	5	49	87	93	(6)
930940	General Expenses	60	36	24	29	49	(20)
931001	Rents-A&G	6,491	5,045	1,446	8,957	5,239	3,718
931008	A&G Rents-IC	31,007	22,834	8,173	19,169	22,454	(3,285)
932000	Maintenance Of Gen Plant-Gas	0	0	0	0	44	(44)
935100	Maint General Plant-Elec	752	3,145	(2,393)	139	50	89
935200	Cust Infor & Computer Control	5	342	(337)	18	174	(156)

		June			July		
Account	Description	2017	2018	Variance	2017	2018	Variance
403002	Depr-Expense	967,879	1,043,178	(75,299)	972,645	1,030,404	(57,759)
403150	Depreciation Expense - ARO	0	0	0	0	0	0
404200	Amort Of Elec Plt - Software	91,419	139,327	(47,908)	173,109	187,266	(14,157)
407355	DSM Deferral - Gas	(70,671)	(10,616)	(60,055)	(57,848)	(96,714)	38,866
408121	Taxes Property-Operating	227,667	242,250	(14,583)	227,667	242,250	(14,583)
408150	State Unemployment Tax	101	(31)	132	82	12	70
408151	Federal Unemployment Tax	394	349	45	(175)	(257)	82
408152	Employer FICA Tax	28,725	37,847	(9,122)	30,483	30,873	(390)
408205	Highway Use Tax	0	0	0	12	1	11
408470	Franchise Tax	387	439	(52)	386	0	386
408700	Fed Social Security Tax-Elec	4,000	5,000	(1,000)	0	0	0
408800	Federal Highway Use Tax-Elec	0	0	0	155	162	(7)
408851	Sales & Use Tax Exp	0	(1,558)	1,558	0	6	(6)
408960	Allocated Payroll Taxes	14,883	8,814	6,069	3,942	17,437	(13,495)
409102	Sit Exp-Utility	(91,129)	(74,868)	(16,261)	0	0	0
409104	Current State Income Tax - PY	0	0	0	0	0	0
409190	Federal Income Tax-Electric-CY	(908,572)	(234,846)	(673,726)	0	0	0
409191	Fed Income Tax-Electric-PY	0	0	0	0	0	0
409195	UTP Tax Expense: Fed Util-PY	0	0	0	0	0	0
410100	DFIT: Utility: Current Year	835,051	281,928	553,123	0	0	0
410102	DSIT: Utility: Current Year	124,058	(73,467)	197,525	0	0	0
410105	DFIT: Utility: Prior Year	0	0	0	0	0	0
410106	DSIT: Utility: Prior Year	0	0	0	0	0	0
411050	Accretion Expense ARO	0	0	0	0	0	0
411100	DFIT: Utility: Curr Year CR	(210,274)	(178,157)	(32,117)	0	0	0
411101	DSIT: Utility: Curr Year CR	(86,015)	102,130	(188,145)	0	0	0
411102	DFIT: Utility: Prior Year CR	0	0	0	0	0	0
411103	DSIT: Utility: Prior Year CR	0	0	0	0	0	0
426510	Other	0	0	0	478	0	478
426891	IC Sale of AR Fees VIE	8,754	16,502	(7,748)	8,731	17,012	(8,281)
711000	Gas Boiler Labor	84	40	44	5	0	5
712000	Gas Production-Other Power Ex	17	9	8	107	9	98
717000	Liq Petro Gas Exp-Vapor Proc	3,784	17,383	(13,599)	2,832	15,460	(12,628)
728000	Liquid Petroleum Gas	0	0	0	0	0	0
735000	Gas Misc Production Exp	2,330	48	2,282	2,032	171	1,861
742000	Maint Gas Production Equipmen	(923)	39,688	(40,611)	121	3,775	(3,654)
801000	Purchases Gas & NGL	972,156	1,119,832	(147,676)	1,068,449	528,050	540,399
801001	Purchases Gas & NGL-Aff	158,035	165,849	(7,814)	158,199	165,938	(7,739)
805002	Unrecovered Purchase Gas Adj	(55,274)	(473,375)	417,101	(440,130)	6,978	(447,108)
805003	Purchase Gas Cost Unbilled Rev	(333,934)	(66,389)	(267,545)	(10,230)	10,685	(20,915)
807000	Gas Purchased Expenses	33,912	40,390	(6,478)	28,935	37,317	(8,382)
807100	I/C Gas Purchased Expenses	2,242	927	1,315	504	466	38
813001	Other Gas Supply Expenses	31,627	(24,448)	56,075	29,469	37,244	(7,775)
850001	Operation Supv & Eng-Tran	0	0	0	0	0	0
870000	Distribution Sys Ops-Supv/Eng	0	0	0	0	0	0
871000	Distribution Load Dispatching	13,008	12,772	236	11,388	7,335	4,053
874000	Mains And Services	311,759	153,538	158,221	676,919	182,564	494,355
875000	Measuring And Reg Stations-Ge	10	12	(2)	17	47	(30)
876000	Measuring & Reg Station-Indus	1,526	782	744	2,315	2,075	240
878000	Meter And House Regulator Exp	76,061	35,048	41,013	209,265	182,500	26,765
879000	Customer Installation Expense	76,778	77,301	(523)	104,612	85,704	18,908
880000	Gas Distribution-Other Expense	234,930	130,276	104,654	116,584	95,752	20,932
885000	Maintenance Dist. System Fac - Supv / Eng	0	0	0	0	0	0
887000	Maintenance of Mains	67,941	76,822	(8,881)	45,831	77,457	(31,626)
889000	Maint-Meas/Reg Stn Equip-Gas	2,345	1,387	958	3,959	5,602	(1,643)
892000	Maintenance of Services	18,579	89,311	(70,732)	48,098	82,570	(34,472)
893000	Maint - Meters And House Reg	22,145	36,973	(14,828)	17,270	32,821	(15,551)
894000	Maint-Other Distribution Equip	6,588	1,415	5,173	5,765	(7,599)	13,364
901000	Supervision-Cust Accts	71,498	38,015	33,483	44,692	20,916	23,776
902000	Meter Reading Expense	42,415	20,595	21,820	24,294	24,244	50
903000	Cust Records & Collection Exp	129,266	115,865	13,401	116,845	161,796	(44,951)
903100	Cust Contracts & Orders-Local	12,806	12,524	282	5,897	3,332	2,565
903200	Cust Billing & Acct	51,808	40,024	11,784	44,429	42,130	2,299
903250	Customer Billing-Common	0	0	0	0	0	0
903300	Cust Collecting-Local	10,802	11,572	(770)	8,989	8,474	515
903400	Cust Receiv & Collect Exp-Edp	3,006	1,772	1,234	2,014	3,114	(1,100)
903891	IC Collection Agent Revenue	(3,170)	(4,372)	1,202	(3,629)	(4,217)	588
904001	BAD DEBT EXPENSE	(34)	0	(34)	3,905	0	3,905
904003	Cust Acctg-Loss On Sale-A/R	0	0	0	0	0	0
904891	IC Loss on Sale of AR VIE	0	0	0	0	0	0
905000	Misc Customer Accts Expenses	15	28	(13)	43	30	13
908000	Cust Asst Exp-Conservation Pro	0	4	(4)	0	0	0
908150	Commer/Indust Assistance Exp	0	0	0	0	0	0
908160	Cust Assist Exp-General	13,448	13,924	(476)	8,564	13,937	(5,373)
909650	Misc Advertising Expenses	0	0	0	1	683	(682)
910000	Misc Cust Serv/Inform Exp	2,482	14,375	(11,893)	15,367	15,707	(340)
910100	Exp-Rs Reg Prod/Svces-CstAccts	8,477	4,524	3,953	683	6,337	(5,654)
911000	Supervision	0	41	(41)	0	37	(37)
912000	Demonstrating & Selling Exp	6,864	12,079	(5,215)	7,317	11,160	(3,843)
913001	Advertising Expense	113	951	(838)	459	150	309
920000	A & G Salaries	201,994	250,780	(48,786)	141,651	192,451	(50,800)
921100	Employee Expenses	4,885	3,427	1,458	9,575	(1,645)	11,321
921101	Employee Exp - NC	0	0	0	0	0	0
921110	Relocation Expenses	140	0	140	0	0	0
921200	Office Expenses	23,810	20,854	2,956	15,116	(9,965)	25,081
921300	Telephone And Telegraph Exp	3	2	1	0	2	(2)
921400	Computer Services Expenses	7,748	9,225	(1,477)	27,292	37,790	(10,498)
921540	Computer Rent (Go Only)	11,713	17,877	(6,164)	10,597	15,717	(5,120)
921600	Other	13	4	9	4	15	(11)
921980	Office Supplies & Expenses	28,891	34,048	(5,157)	26,797	34,902	(8,105)
922000	Admin Exp Transfer	0	0	0	0	8	(8)
923000	Outside Services Employed	96,798	255,096	(158,298)	95,832	139,408	(43,576)
923980	Outside Services Employee &	299	(855)	1,154	(1,898)	(1,092)	(806)
924000	Property Insurance	(82)	(162)	80	789	699	90
924050	Inter-Co Prop Ins Exp	5,977	292	5,685	5,977	292	5,685
924980	Property Insurance For Corp.	4,605	4,390	215	4,605	4,390	215
925000	Injuries & Damages	55,994	1,020	54,974	4,990	880	4,110
925051	INTER-CO GEN LIAB EXP	22,825	5,100	17,725	22,825	5,058	17,767
925200	Injuries And Damages-Other	205	195	10	208	209	(1)
925300	Environmental Inj & Damages	439	85,939	(85,500)	0	0	0
925980	Injuries And Damages For Corp	358	363	(5)	358	363	(5)
926000	EMPL PENSIONS AND BENEFITS	238,314	198,206	40,108	(25,170)	126,528	(151,698)
926430	Employees'Recreation Expense	0	1	(1)	11	34	(23)
926600	Employee Benefits-Transferred	72,638	59,016	13,622	(1,272)	79,532	(80,804)
926999	Non Serv Pension (ASU 2017-07)	0	(26,172)	26,172	0	(26,172)	26,172
928000	Regulatory Expenses (Go)	0	0	0	0	0	0
928006	State Reg Comm Proceeding	16,895	15,471	1,424	15,471	15,694	(223)
929000	Duplicate Chrgs-Enrgy To Exp	(563)	(268)	(295)	(93)	(49)	(44)
929500	Admin Exp Transf	(15,135)	(11,094)	(4,041)	(19,491)	(19,770)	279
930150	Miscellaneous Advertising Exp	125	922	(797)	696	272	424
930200	Misc General Expenses	3,613	14,232	(10,619)	865	5,998	(5,133)
930210	Industry Association Dues	0	0	0	0	0	0
930220	Exp Of Servicing Securities	(116)	(16)	(100)	1	(8)	9
930230	Dues To Various Organizations	272	0	272	0	656	(656)
930240	Director'S Expenses	32	11	21	1,354	1,598	(244)
930250	Buy\Sell Transf Employee Homes	833	206	627	1,853	10	1,843
930700	Research & Development	40	235	(195)	34	18	16
930940	General Expenses	11	58	(47)	48	348	(300)
931001	Rents-A&G	6,867	4,746	2,121	8,636	6,592	2,044
931008	A&G Rents-IC	19,063	22,572	(3,509)	19,542	23,597	(4,055)
932000	Maintenance Of Gen Plant-Gas	(35)	3,425	(3,461)	0	143	(143)
935100	Maint General Plant-Elec	(890)	(3,195)	2,305	(198)	15	(213)
935200	Cust Infor & Computer Control	54	593	(539)	15	(398)	413

STAFF-DR-01-030(b)
EXCEL
ATTACHMENT

PROVIDED ON CD

DUKE ENERGY KENTUCKY, INC
CASE NO. 2018-00261
COMPARISON OF GAS ACCOUNT BALANCES
FOR THE BASE PERIOD
AND THE MOST RECENT THREE CALENDAR YEARS

Line No.	Account No.	Account Title	2015	2016	2016 vs. 2015 Variance	2016 vs. 2015 % Change	2017	2017 vs. 2016 Variance	2017 vs. 2016 % Change	Base Period	2017 vs. Base Period Variance	2017 vs. Base Period % Change
1	403	Depreciation Expenses	10,701,058	10,931,716	230,658	2.16%	11,591,542	659,826	6.04%	12,841,958	1,250,416	10.79%
2	404	Amortization Expenses	814,067	831,341	17,274	2.12%	1,422,574	591,233	71.12%	1,553,689	131,115	9.22%
3	407	Regulatory Debits and Credits	2,098,950	2,793,990	695,040	33.11%	544,974	(2,249,016)	(80.49)%	(801,635)	(1,346,609)	(247.10)%
4	408	Taxes Other Than Income Taxes	4,077,676	4,858,897	781,221	19.16%	3,364,888	(1,494,009)	(30.75)%	3,606,329	241,441	7.18%
5	409	Current Income Taxes	8,876,706	8,013,759	(862,947)	(9.72)%	(8,552,948)	(16,566,707)	(206.73)%	4,039,644	12,592,592	147.23%
6	410	Deferred Income Taxes - Deferrals	9,849,896	6,704,810	(3,145,086)	(31.93)%	25,035,734	18,330,924	273.40%	(589,838)	(25,625,572)	(102.36)%
7	411	Deferred Income Taxes - Writebacks	(11,138,243)	(10,363,907)	774,336	6.95%	(12,385,872)	(2,021,965)	(19.51)%	(67,241)	12,318,631	99.46%
8	426	Sale of AR	75,945	103,017	27,072	35.65%	114,821	11,804	11.46%	111,507	(3,314)	(2.99)%
9	711	Gas Boiler Labor	5,597	4,770	(827)	(14.78)%	5,663	893	18.72%	8,534	2,871	50.70%
10	712	Gas Production - Other Expense	7,858	7,792	(66)	(0.84)%	17,096	9,304	119.40%	13,405	(3,691)	(21.59)%
11	717	Liquid Petroleum Gas Expense	4,961	96,515	91,554	1845.47%	83,244	(13,271)	(13.75)%	116,764	33,520	40.27%
12	728	Liquid Petroleum Gas	782,339	834,050	51,711	6.61%	588,951	(245,099)	(29.39)%	1,677,312	1,088,361	184.80%
13	735	Miscellaneous Prod Expense	44,796	50,313	5,517	12.32%	45,911	(4,402)	(8.75)%	120,585	74,674	162.65%
14	736	Rents	11,167	0	(11,167)	(100.00)%	0	0	-	0	0	-
15	742	Production Equipment	106,575	71,040	(35,535)	(33.34)%	52,927	(18,113)	(25.50)%	111,249	58,322	110.19%
16	801	Natural Gas Field Line Purchase	40,598,667	34,678,066	(5,920,601)	(14.58)%	37,161,991	2,483,925	7.16%	39,410,142	2,248,151	6.05%
17	805	Unrecovered Purch Gas Adjustment	1,011,153	(2,066,943)	(3,078,096)	(304.41)%	86,609	2,153,552	104.19%	4,374,701	4,288,092	4951.09%
18	807	Gas Purchased Expenses	428,782	378,922	(49,860)	(11.63)%	430,480	51,558	13.61%	507,218	76,738	17.83%
19	813	Other Gas Supply Expenses	964,793	875,719	(89,074)	(9.23)%	523,005	(352,714)	(40.28)%	163,893	(359,112)	(68.66)%
20	850	Operation Supervision & Engineering	0	0	0	-	481	481	-	0	(481)	(100.00)%
21	859	Other Expenses	6,490	6,885	395	6.09%	2,235	(4,650)	(67.54)%	0	(2,235)	(100.00)%
22	870	Dist Supervision & Engineering	112,057	(1,491)	(113,548)	(101.33)%	0	1,491	100.00%	0	0	-
23	871	Distribution Load Dispatching	192,263	191,978	(285)	(0.15)%	155,692	(36,286)	(18.90)%	168,926	13,234	8.50%
24	874	Mains And Services	2,965,174	2,608,224	(356,950)	(12.04)%	2,596,130	(12,094)	(0.46)%	2,353,623	(242,507)	(9.34)%
25	875	Measuring & Reg Stations - Gen	1,586	69,269	67,683	4267.53%	1,523	(67,746)	(97.80)%	6,382	4,859	319.04%
26	876	Measuring & Reg Stations - Ind	15,648	40,548	24,900	159.13%	20,754	(19,794)	(48.82)%	4,540	(16,214)	(78.12)%
27	878	Meter And House Regulators	1,085,154	1,116,219	31,065	2.86%	2,448,922	1,332,703	119.38%	1,681,076	(767,846)	(31.35)%
28	879	Customer Installations	947,329	1,340,845	393,516	41.54%	1,264,352	(76,493)	(5.70)%	1,210,113	(54,239)	(4.29)%
29	880	Gas Distribution Other Expense	1,476,730	2,619,290	1,142,560	77.37%	2,597,986	(21,304)	(0.81)%	1,987,140	(610,846)	(23.51)%
30	881	Rents Interco	0	0	0	-	0	0	-	0	0	-
31	885	Maint- Supervision & Engineer	86,031	(2,635)	(88,666)	(103.06)%	0	2,635	100.00%	0	0	-
32	887	Maintenance Of Mains	702,408	761,041	58,633	8.35%	922,883	161,842	21.27%	1,679,396	756,513	81.97%
33	889	Maint- Measuring & Reg Stat -	39,908	45,377	5,469	13.70%	47,473	2,096	4.62%	46,829	(644)	(1.36)%
34	890	Maint- Measuring & Reg Stat -	3,977	1,097	(2,880)	(72.42)%	0	(1,097)	(100.00)%	0	0	-
35	892	Maintenance Of Services	625,693	400,857	(224,836)	(35.93)%	759,836	358,979	89.55%	542,588	(217,248)	(28.59)%
36	893	Maintenance Of Meters & House	301,184	543,580	242,396	80.48%	284,008	(259,572)	(47.75)%	341,546	57,538	20.26%
37	894	Maint - Other Distribution Equipment	25,279	45,930	20,651	81.69%	5,825	(40,105)	(87.32)%	(50,557)	(56,382)	(967.93)%
38	901	Supervision & Engineering	43,817	404,392	360,575	822.91%	587,612	183,220	45.31%	367,778	(219,834)	(37.41)%
39	902	Meter Reading Expense	710,370	618,439	(91,931)	(12.94)%	467,970	(150,469)	(24.33)%	206,301	(261,669)	(55.92)%
40	903	Customer Records & Collections	2,589,591	2,798,436	208,845	8.06%	2,568,495	(229,941)	(8.22)%	2,803,936	235,441	9.17%
41	904	Uncollectible Accounts	242,191	185,695	(56,496)	(23.33)%	3,920	(181,775)	(97.89)%	289,362	285,442	7281.68%
42	905	Miscellaneous Customers Accounts	757	318	(439)	(57.99)%	314	(4)	(1.26)%	152	(162)	(51.59)%
43	908	Customer Assistance Activities	157,153	166,854	9,701	6.17%	139,343	(27,511)	(16.49)%	132,042	(7,301)	(5.24)%
44	909	Informational & Instructional Adver	3,594	200	(3,394)	(94.44)%	1,310	1,110	555.00%	575	(735)	(56.11)%
45	910	Misc. Cust. Serv. & Info	471,707	338,705	(133,002)	(28.20)%	310,786	(27,919)	(8.24)%	302,182	(8,604)	(2.77)%
46	911	Supervision	0	0	0	-	19	19	-	10,459	10,440	54947.37%
47	912	Demonstrating & Selling Exp	114,357	90,223	(24,134)	(21.10)%	99,009	8,786	9.74%	152,353	53,344	53.88%
48	913	Advertising	490	3,768	3,278	668.98%	7,303	3,535	93.82%	5,418	(1,885)	(25.81)%
49	920	Administrative & General Salaries	2,182,998	1,910,444	(272,554)	(12.49)%	1,750,117	(160,327)	(8.39)%	2,105,665	355,548	20.32%
50	921	Office Supplies & Expenses	1,054,946	908,525	(146,421)	(13.88)%	1,014,537	106,012	11.67%	1,082,826	68,289	6.73%
51	922	Administrative Expenses Transfer Cr	0	475	475	-	331	(144)	(30.32)%	287	(44)	(13.29)%
52	923	Outside Services Employed	883,801	536,163	(347,638)	(39.33)%	1,092,343	556,180	103.73%	921,498	(170,845)	(15.64)%
53	924	Property Insurance	158,576	129,250	(29,326)	(18.49)%	128,252	(998)	(0.77)%	65,063	(63,189)	(49.27)%
54	925	Injuries & Damages	463,576	513,100	49,524	10.68%	423,476	(89,624)	(17.47)%	121,890	(301,586)	(71.22)%
55	926	Employee Pension & Benefits	2,468,507	1,642,940	(825,567)	(33.44)%	1,815,518	172,578	10.50%	2,609,947	794,429	43.76%
56	928	State Reg. Commission Expense	216,289	218,031	1,742	0.81%	194,195	(23,836)	(10.93)%	194,196	1	-
57	929	Duplicate Charges-Credit	(193,419)	(270,461)	(77,042)	(39.83)%	(266,488)	3,973	1.47%	(148,071)	118,417	44.44%
58	930.1	General Advertising Exp	10,716	7,162	(3,554)	(33.17)%	8,689	1,527	21.32%	34,145	25,456	292.97%
59	930.2	Miscellaneous General Expenses	119,097	323,575	204,478	171.69%	215,142	(108,433)	(33.51)%	228,467	13,325	6.19%
60	931	Rents	413,324	574,016	160,692	38.88%	439,855	(134,161)	(23.37)%	331,598	(108,257)	(24.61)%
61	932	Maintenance of General Plant - Gas	7,684	5,666	(2,018)	(26.26)%	2,527	(3,139)	(55.40)%	4,204	1,677	66.36%
62	935	Maintenence of General Plant	0	0	0	-	0	0	-	5,888	5,888	-

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-031

REQUEST:

Provide a schedule of gas operations net income, per MCF sold, per company books for the base period and the three calendar years preceding the base period. This data should be provided as shown in Schedule 31.

RESPONSE:

See STAFF-DR-01-031 Attachment.

PERSON RESPONSIBLE: Michael Covington

STAFF-DR-01-031
EXCEL
ATTACHMENT

PROVIDED ON CD

DUKE ENERGY KENTUCKY, INC.
CASE NO. 2018-00261
GAS NET INCOME PER MCF SOLD
FOR THE CALENDAR YEARS 2015 THROUGH 2017
AND FOR THE BASE PERIOD

STAFF-DR-01-031
Schedule 31
Page 1 of 1

LINE NO.	DESCRIPTION	12 Months Ended December Three Most Recent Calendar Years 2015	2016	2017	BASE PERIOD
1	**Operating Income**				
2	Operating Revenues	104,452,723	93,009,868	94,164,214	102,436,819
3	**Operating Income Deductions**				
4	**Operating and Maintenance Expenses:**				
5	Gas Production Expenses	963,293	1,064,480	793,792	2,047,849
6	Purchased Gas Expenses	42,038,602	32,990,045	37,679,080	43,784,843
7	Other Gas Supply Expenses	964,793	875,719	523,005	671,111
8	Transmission Expenses	6,490	6,885	2,716	0
9	Distribution Expenses	8,580,421	9,780,129	11,105,384	9,971,602
10	Customer Accounts Expenses	3,586,726	4,007,280	3,628,311	3,779,036
11	Customer Service and Informational Expenses	632,454	505,759	451,439	434,799
12	Sales Expenses	114,847	93,991	106,331	168,230
13	Administerative and General Expenses	7,786,095	6,498,886	6,818,494	7,557,603
14	Other	2,098,950	2,793,990	544,974	(801,635)
15	Total (Line 5 through Line 14)	66,772,671	58,617,164	61,653,526	67,613,438
16	Depreciation Expense	10,701,058	10,931,716	11,591,542	12,841,958
17	Amort. & Depl. of Utility Plant	814,067	831,341	1,422,574	1,553,689
18	Taxes Other Than Income Taxes	4,077,676	4,858,897	3,364,888	3,606,329
19	Income Taxes - Federal	7,940,333	6,908,014	(7,656,112)	3,692,225
20	Income Taxes - Other	936,373	1,105,745	(896,836)	347,419
21	Provision for Deferred Income Taxes - Net	(1,219,192)	(3,590,389)	12,717,213	(589,838)
22	Investment Tax Credit Adj - Net	(69,155)	(68,708)	(67,351)	(67,241)
23	Gains From Disp of Allow - Credit	0	0	0	0
24	Accretion Expense	0	0	0	0
25	Total Utility Operating Expenses	89,953,831	79,593,780	82,129,444	88,997,979
26	Net Utility Operating Income	14,498,892	13,416,088	12,034,770	13,438,840
27	**Other Income and Deductions**				
28	**Other Income:**				
29	Nonutility Operating Income	0	0	0	0
30	Equity in Earnings of Subsidiary Companies	0	0	0	0
31	Interest and Dividend Income	0	0	0	157,130
32	Allowance for Funds Used During Const	52,466	293,820	600,389	982,198
33	Miscellaneous Nonoperating Income	0	0	0	29,173
34	Gain on Disposition of Property	0	0	0	0
35	Total Other Income	52,466	293,820	600,389	1,168,501
36	**Other Income Deductions:**				
37	Loss on Disposition of Property	0	0	0	0
38	Miscellaneous Income Deductions	0	0	0	0
39	Total Other Income Deductions	0	0	0	0
40	**Taxes Applicable to Other Income and Deductions**				
41	Income Taxes and Investment Tax Credits	0	0	0	0
42	Taxes Other Than Income Taxes	0	0	0	0
43	Total Taxes on Other Income and Deductions	0	0	0	0
44	Net Other Income and Deductions	52,466	293,820	600,389	1,168,501
45	**Interest Charges**				
46	Interest on Long Term Debt	3,740,374	4,229,545	4,493,448	5,736,149
47	Amortization of Debt Discount and Expense	128,397	230,016	92,749	119,047
48	Amortization of Loss on Reacquired Debt	81,909	81,909	81,909	40,954
49	Amortization of Premium on Debt - Credit	0	0	0	0
50	Interest on Debt to Assoc. Companies	58,197	70,423	139,450	151,321
51	Other Interest Expense	539,468	456,757	425,506	263,077
52	Allow For Brwd Funds Used Dur Const - Credit	(20,041)	(100,423)	(205,612)	(345,489)
53	Net Interest Charges	4,528,304	4,968,227	5,027,450	5,965,059
54	Net Income	10,023,054	8,741,681	7,607,709	8,642,282
55	1,000 MCF Sold	13,203,617	11,941,728	12,037,889	13,892,110
56	Net Income per MCF Sold	$ 0.76	$ 0.73	$ 0.63	$ 0.62

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-032

REQUEST:

Provide the comparative operating statistics for gas operations as shown in Schedule 32.

RESPONSE:

See STAFF-DR-01-032 Attachment.

PERSON RESPONSIBLE: Michael Covington

STAFF-DR-01-032
EXCEL
ATTACHMENT

PROVIDED ON CD

DUKE ENERGY KENTUCKY, INC.
Case No. 2018-00261
Comparative Operating Statistics - Gas Operations
For the Calendar Years 2015 through 2017
(Total Company)

Line No.	Item (a)	Three Most Recent Calendar Years 2015 (b)	Inc. (c)	2016 (d)	Inc. (e)	2017 (f)	Inc. (g)
1	Cost per MCF of purchased gas	$3.18	(21.69)%	$2.76	(13.22)%	$3.13	13.28%
2	Cost of propane gas per MCF equivalent for peak shaving	$15.41	76.11%	$12.83	(16.74)%	$11.51	(10.29)%
3	Cost per MCF of gas sold	$4.08	(23.45)%	$3.73	(8.58)%	$4.16	11.53%
4	Transmission Maintenance Cost	$0	-	$0	-	$0	-
	per transmission mile	0.00	-	0.00	-	0.00	-
5	Distribution Maintenance Cost	$1,784,480	(11.15)%	$1,795,247	0.60%	$2,020,025	12.52%
	per distribution mile	$1,246.15	(12.89)%	$1,256.30	0.81%	$1,390.24	10.66%
6	Sales promotion expense	$114,847	(45.01)%	$93,991	(18.16)%	$106,331	13.13%
	per customer	$1.19	(45.27)%	$0.96	(18.89)%	$1.08	12.37%
7	Administration & general expense	$7,786,095	18.26%	$6,498,886	(16.53)%	$6,818,494	4.92%
	per customer	$80.38	17.67%	$66.52	(17.23)%	$69.34	4.24%
8	Wages and salaries - charged expense: per average employee	N/A	N/A	N/A	N/A	N/A	N/A
9	Depreciation expense:	$10,701,058	1.24%	$10,931,716	2.16%	$11,591,542	6.04%
10	per $100 of average gross depreciable plant in service	$2.41	(0.82)%	$2.38	(1.33)%	$2.38	0.38%
11	Rents:	$413,324	(9.30)%	$574,016	38.88%	$439,855	(23.37)%
12	per $100 of average gross plant in service	$0.09	(10.31)%	$0.12	33.33%	$0.09	(26.72)%
13	Property taxes:	$3,453,996	(5.63)%	$4,212,095	21.95%	$2,749,198	(34.73)%
14	per $100 of average net plant in service	1.17	(5.65)%	1.38	17.95%	0.84	(39.13)%
15	Payroll taxes:	N/A	N/A	N/A	N/A	N/A	N/A
16	Payroll taxes: per average employee whose salary is charged to expense	N/A	N/A	N/A	N/A	N/A	N/A
17	Interest expense:	$ 4,528,304		$ 4,968,227		$ 5,027,449	
18	per $100 of average debt outstanding	N/A	N/A	N/A	N/A	N/A	N/A
19	per $100 of average plant investment	N/A	N/A	N/A	N/A	N/A	N/A
20	per MCF sold	$0.34	0.26%	$0.42	21.28%	$0.42	0.38%
21	Meter reading expense:	$710,370	38.14%	$618,439	(12.94)%	$467,970	(24.33)%
22	per meter	$7.33	37.45%	$6.33	(13.68)%	$4.76	(24.82)%

(1) Duke Energy Kentucky does not allocate interest expense between gas and electric operations. Therefore, interest expense per $100 was not calculated.

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-033

REQUEST:

List separately the budgeted and actual numbers of full- and part-time employees by employee group, by month and by year, for the three most recent calendar years, the base period, and the forecasted test period.

RESPONSE:

See STAFF-DR-01-033 Attachment for actual headcount. The Company does not track budgeted headcount in this manner.

PERSON RESPONSIBLE: Renee H. Metzler

STAFF-DR-01-033
EXCEL
ATTACHMENT

PROVIDED ON CD

Actual Headcount for Kentucky Pay Company

Count of Worker Id ME			Month											
Year	Resp Center Level 4 Node Description MERCLVL	Fulltime Parttime Description ME	01	02	03	04	05	06	07	08	09	10	11	12
2014	Commercial Operations	Full-Time								18	17	17	17	21
	Customer Operations	Full-Time	7	7	7	7	11	11	11	11	11	10	10	10
		Part-Time	6	5	5	4	6	6	6	6	6	5	5	5
	Distribution (1DF)	Full-Time	60	60	58	58	58	57	58	39	38	38	39	36
	Fossil Hydro Operations	Full-Time	77	77	75	78	80	79	77	77	77	77	76	76
	Operations Support	Full-Time	1	1										
	Transmission	Full-Time									1			
	Utility Operations	Full-Time	20	21	21	21	21	21	21	19	19	19	19	20
2014 Total			171	171	166	168	176	174	173	170	169	166	166	168
2015	Commercial Operations	Full-Time	20	20	23	22	22	22	22	22	22	22	22	17
	Customer Operations	Full-Time	11	11	11	14	16	19	19	19	19	19	18	18
		Part-Time	8	8	9	9	9	1						
	Distribution (1DF)	Full-Time	43	46	60	63	63	61	58	59	59	61	61	59
	Fossil Hydro Operations	Full-Time	75	75	74	74	73	71	69	68	68	72	73	72
	Utility Operations	Full-Time	20	20	20	19	19	18	17	17	17	18	18	21
2015 Total			177	180	197	201	202	192	185	185	185	192	192	187
2016	Commercial Operations	Full-Time	15	15	17	17	16	16	16	16	16	16	16	16
	Customer Operations	Full-Time	18	18	18	18	18	18	18	19	19	18	18	18
	Distribution (1DF)	Full-Time	62	64	61	59	58	56	56	58	58	56	56	54
	Fossil Hydro Operations	Full-Time	72	72	71	72	66	66	66	65	64	66	68	67
	Utility Operations	Full-Time	24	24	25	24	24	24	29	33	32	32	32	30
2016 Total			191	193	192	190	182	180	185	191	189	188	190	185
2017	Commercial Operations	Full-Time	17	17	17	17	17	17	18	18	19	19	19	17
	Customer Operations	Full-Time	19	19	20	20	22	22	22	25	25	25	25	24
		Part-Time								9	9	9	9	9
	Distribution (1DF)	Full-Time	55	55	53	52	59	59	60	66	66	67	67	63
	Fossil Hydro Operations	Full-Time	67	71	71	72	72	71	72	79	78	77	78	78
	Utility Operations	Full-Time	30	30	31	31	31	31	30	35	35	34	34	32

Count of Worker Id ME		Month											
Year	Fulltime Parttime Description ME	01	02	03	04	05	06	07	08	09	10	11	12
2014	Full-Time	165	166	161	164	170	168	167	164	163	161	161	163
	Part-Time	6	5	5	4	6	6	6	6	6	5	5	5
2014 Total		171	171	166	168	176	174	173	170	169	166	166	168
2015	Full-Time	169	172	188	192	193	191	185	185	185	192	192	187
	Part-Time	8	8	9	9	9	1						
2015 Total		177	180	197	201	202	192	185	185	185	192	192	187
2016	Full-Time	191	193	192	190	182	180	185	191	189	188	190	185
2016 Total		191	193	192	190	182	180	185	191	189	188	190	185
2017	Full-Time	188	192	192	192	201	200	202	223	223	222	223	222
	Part-Time								9	9	9	9	9
2017 Total		188	192	192	192	201	200	202	232	232	231	232	231
2018	Full-Time	223	218	216	222	220							
	Part-Time	9	9	9	9	9							
2018 Total		232	227	225	231	229							

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-034

REQUEST:

Provide the information requested in Schedule 34 for the budgeted and actual regular wages, overtime wages, and total wages by employee group, by month, for the five most recent calendar years. Explain in detail any variance exceeding 5 percent in any one month.

RESPONSE:

See STAFF-DR-01-034 Attachment.

PERSON RESPONSIBLE: Renee H. Metzler

STAFF-DR-01-034
EXCEL
ATTACHMENT

PROVIDED ON CD

Duke Energy Kentucky
Case No. 2018-00261
Monthly Payroll Variance Analysis
STAFF-DR-01-034

		Monthly Budget			Monthly Actual			Variance Percent		
Date	Employee Group	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Jan-13	Union				421,351	45,274	466,625			
Jan-13	Non-Union				292,377	842	293,219			
		664,581	41,145	705,726	713,728	46,116	759,844	7.4%	12.1%	7.7%
Feb-13	Union				329,440	62,672	392,113			
Feb-13	Non-Union				290,325	764	291,089			
		598,596	42,995	641,591	619,766	63,437	683,202	3.5%	47.5%	6.5%
Mar-13	Union				351,667	67,198	418,866			
Mar-13	Non-Union				308,447	852	309,299			
		623,698	41,975	665,673	660,114	68,050	728,165	5.8%	62.1%	9.4%
Apr-13	Union				344,176	96,324	440,500			
Apr-13	Non-Union				310,361	1,472	311,833			
		615,280	32,998	648,278	654,537	97,796	752,333	6.4%	196.4%	16.1%
May-13	Union				527,960	173,398	701,358			
May-13	Non-Union				324,511	2,346	326,857			
		766,241	55,971	822,212	852,471	175,745	1,028,215	11.3%	214.0%	25.1%
Jun-13	Union				343,744	116,736	460,480			
Jun-13	Non-Union				314,602	1,436	316,038			
		630,876	33,188	664,064	658,346	118,172	776,518	4.4%	256.1%	16.9%
Jul-13	Union				349,181	120,628	469,809			

Duke Energy Kentucky
Case No. 2018-00261
Monthly Payroll Variance Analysis
STAFF-DR-01-034

		Monthly Budget			Monthly Actual			Variance Percent		
Date	Employee Group	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Jul-13	Non-Union				308,216	2,370	310,586			
		625,558	32,999	658,557	657,397	122,998	780,395	5.1%	272.7%	18.5%
Aug-13	Union				350,368	117,857	468,225			
Aug-13	Non-Union				317,221	2,352	319,572			
		633,354	50,251	683,605	667,588	120,208	787,797	5.4%	139.2%	15.2%
Sep-13	Union				349,616	113,942	463,557			
Sep-13	Non-Union				304,862	2,102	306,964			
		624,436	36,863	661,299	654,478	116,044	770,521	4.8%	214.8%	16.5%
Oct-13	Union				370,831	132,542	503,372			
Oct-13	Non-Union				304,651	1,998	306,648			
		616,434	37,886	654,320	675,482	134,539	810,020	9.6%	255.1%	23.8%
Nov-13	Union				512,230	178,905	691,135			
Nov-13	Non-Union				315,668	1,878	317,546			
		776,087	73,794	849,880	827,898	180,783	1,008,681	6.7%	145.0%	18.7%
Dec-13	Union				307,011	70,608	377,619			
Dec-13	Non-Union				302,377	1,643	304,019			
		680,784	43,026	723,810	609,388	72,251	681,638	-10.5%	67.9%	-5.8%
YTD - 13	Union				4,557,576	1,296,084	5,853,660			
YTD - 13	Non-Union				3,693,616	20,055	3,713,672			
		7,855,925	523,090	8,379,015	8,251,192	1,316,139	9,567,331	5.0%	151.6%	14.2%

Duke Energy Kentucky
Case No. 2018-00261
Monthly Payroll Variance Analysis
STAFF-DR-01-034

Date	Employee Group	Monthly Budget Regular	Monthly Budget OT	Monthly Budget Total	Monthly Actual Regular	Monthly Actual OT	Monthly Actual Total	Variance Percent Regular	Variance Percent OT	Variance Percent Total
		Variances are primarily driven by overtime hours greater than assumed in the budget and timing differences of planned work compared to the budget								
Jan-14	Union				393,134	66,963	460,097			
Jan-14	Non-Union				311,942	1,034	312,976			
		694,064	39,135	733,200	705,076	67,998	773,074	1.6%	73.8%	5.4%
Feb-14	Union				316,891	59,637	376,528			
Feb-14	Non-Union				330,289	1,165	331,454			
		638,719	47,375	686,093	647,180	60,803	707,983	1.3%	28.3%	3.2%
Mar-14	Union				340,470	2,194	342,664			
Mar-14	Non-Union				348,101	85,835	433,936			
		675,695	46,421	722,116	688,571	88,029	776,600	1.9%	89.6%	7.5%
Apr-14	Union				342,447	136,641	479,088			
Apr-14	Non-Union				342,849	1,163	344,012			
		653,455	31,423	684,879	685,296	137,804	823,100	4.9%	338.5%	20.2%
May-14	Union				493,946	226,941	720,887			
May-14	Non-Union				340,361	2,056	342,417			
		824,599	60,721	885,320	834,307	228,997	1,063,303	1.2%	277.1%	20.1%

Duke Energy Kentucky
Case No. 2018-00261
Monthly Payroll Variance Analysis
STAFF-DR-01-034

		Monthly Budget			Monthly Actual			Variance Percent		
Date	Employee Group	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Jun-14	Union				310,251	152,717	462,968			
Jun-14	Non-Union				317,351	1,559	318,910			
		690,892	37,504	728,395	627,602	154,276	781,878	-9.2%	311.4%	7.3%
Jul-14	Union				342,205	118,031	460,236			
Jul-14	Non-Union				325,889	1,865	327,754			
		681,344	31,484	712,827	668,094	119,896	787,990	-1.9%	280.8%	10.5%
Aug-14	Union				323,516	126,245	449,761			
Aug-14	Non-Union				335,995	2,140	338,135			
		688,734	56,531	745,264	659,511	128,385	787,896	-4.2%	127.1%	5.7%
Sep-14	Union				313,137	96,114	409,251			
Sep-14	Non-Union				327,440	2,055	329,495			
		678,327	35,460	713,787	640,576	98,169	738,745	-5.6%	176.8%	3.5%
Oct-14	Union				486,852	156,286	643,138			
Oct-14	Non-Union				356,118	2,102	358,220			
		777,565	38,962	816,528	842,970	158,388	1,001,358	8.4%	306.5%	22.6%
Nov-14	Union				308,025	113,387	421,412			
Nov-14	Non-Union				365,941	1,534	367,475			
		734,978	71,935	806,913	673,966	114,921	788,888	-8.3%	59.8%	-2.2%
Dec-14	Union				327,860	74,417	402,277			
Dec-14	Non-Union				367,485	2,061	369,546			

Duke Energy Kentucky
Case No. 2018-00261
Monthly Payroll Variance Analysis
STAFF-DR-01-034

		Monthly Budget			Monthly Actual			Variance Percent		
Date	Employee Group	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
		698,388	47,477	745,865	695,345	76,478	771,822	-0.4%	61.1%	3.5%
YTD - 14	Union				4,298,733	1,413,215	5,711,948			
YTD - 14	Non-Union				4,069,760	20,928	4,090,688			
		8,436,759	544,428	8,981,187	8,368,493	1,434,143	9,802,637	-0.8%	163.4%	9.1%

Variances are primarily driven by overtime hours greater than assumed in the budget and timing differences of planned work compared to the budget

Jan-15	Union				434,120	56,893	491,013			
Jan-15	Non-Union				363,747	1,148	364,895			
		723,585	57,326	780,911	797,867	58,041	855,908	10.3%	1.2%	9.6%
Feb-15	Union				328,614	58,564	387,178			
Feb-15	Non-Union				354,261	1,102	355,363			
		678,271	71,868	750,139	682,875	59,666	742,541	0.7%	-17.0%	-1.0%
Mar-15	Union				334,994	66,970	401,964			
Mar-15	Non-Union				383,872	1,293	385,165			
		709,732	70,815	780,547	718,866	68,263	787,129	1.3%	-3.6%	0.8%
Apr-15	Union				324,448	80,537	404,985			
Apr-15	Non-Union				373,639	1,694	375,333			
		702,982	54,438	757,420	698,086	82,232	780,318	-0.7%	51.1%	3.0%

Duke Energy Kentucky
Case No. 2018-00261
Monthly Payroll Variance Analysis
STAFF-DR-01-034

		Monthly Budget			Monthly Actual			Variance Percent		
Date	Employee Group	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
May-15	Union				482,972	129,949	612,921			
May-15	Non-Union				404,116	2,016	406,132			
		807,603	71,120	878,723	887,088	131,966	1,019,054	9.8%	85.6%	16.0%
Jun-15	Union				321,399	72,891	394,290			
Jun-15	Non-Union				401,538	2,427	403,965			
		725,473	60,642	786,115	722,936	75,318	798,254	-0.3%	24.2%	1.5%
Jul-15	Union				357,085	77,482	434,567			
Jul-15	Non-Union				397,238	1,743	398,981			
		714,596	54,431	769,027	754,323	79,225	833,548	5.6%	45.6%	8.4%
Aug-15	Union				331,597	105,834	437,431			
Aug-15	Non-Union				367,757	3,183	370,940			
		716,613	80,384	796,997	699,353	109,018	808,371	-2.4%	35.6%	1.4%
Sep-15	Union				351,944	134,714	486,658			
Sep-15	Non-Union				401,766	3,022	404,788			
		723,280	55,619	778,899	753,710	137,737	891,447	4.2%	147.6%	14.4%
Oct-15	Union				531,430	243,852	775,282			
Oct-15	Non-Union				443,836	4,453	448,289			
		789,269	58,238	847,507	975,266	248,305	1,223,571	23.6%	326.4%	44.4%
Nov-15	Union				411,368	140,535	551,903			

Duke Energy Kentucky
Case No. 2018-00261
Monthly Payroll Variance Analysis
STAFF-DR-01-034

		Monthly Budget			Monthly Actual			Variance Percent		
Date	Employee Group	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Nov-15	Non-Union				392,290	2,431	394,721			
		710,549	79,902	790,451	803,659	142,966	946,625	13.1%	78.9%	19.8%
Dec-15	Union				494,030	150,545	644,575			
Dec-15	Non-Union				386,932	3,074	390,006			
		711,887	71,650	783,537	880,962	153,619	1,034,581	23.8%	114.4%	32.0%
YTD - 15	Union				4,704,001	1,318,766	6,022,767			
YTD - 15	Non-Union				4,670,991	27,588	4,698,579			
		8,713,840	786,433	9,500,273	9,374,992	1,346,354	10,721,346	7.6%	71.2%	12.9%

Variances are primarily driven by overtime hours greater than assumed in the budget and timing differences of planned work compared to the budget

Jan-16	Union				479,158	74,041	553,199			
Jan-16	Non-Union				410,016	1,301	411,317			
		840,949	69,555	910,504	889,174	75,342	964,516	5.7%	8.3%	5.9%
Feb-16	Union				382,874	105,486	488,360			
Feb-16	Non-Union				426,999	1,096	428,095			
		760,290	69,977	830,267	809,873	106,581	916,454	6.5%	52.3%	10.4%
Mar-16	Union				384,470	96,552	481,022			
Mar-16	Non-Union				433,665	1,627	435,292			

Duke Energy Kentucky
Case No. 2018-00261
Monthly Payroll Variance Analysis
STAFF-DR-01-034

		Monthly Budget			Monthly Actual			Variance Percent		
Date	Employee Group	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
		874,090	82,890	956,980	818,135	98,179	916,314	-6.4%	18.4%	-4.2%
Apr-16	Union				601,002	182,251	783,253			
Apr-16	Non-Union				439,864	1,834	441,698			
		899,885	64,956	964,841	1,040,866	184,085	1,224,951	15.7%	183.4%	27.0%
May-16	Union				417,994	149,465	567,459			
May-16	Non-Union				427,606	1,007	428,613			
		872,543	84,404	956,947	845,600	150,473	996,073	-3.1%	78.3%	4.1%
Jun-16	Union				393,895	114,937	508,832			
Jun-16	Non-Union				423,526	2,309	425,835			
		914,576	89,195	1,003,771	817,422	117,247	934,669	-10.6%	31.5%	-6.9%
Jul-16	Union				438,007	114,044	552,051			
Jul-16	Non-Union				412,785	2,784	415,569			
		886,450	90,063	976,513	850,792	116,829	967,621	-4.0%	29.7%	-0.9%
Aug-16	Union				510,067	147,931	657,998			
Aug-16	Non-Union				432,178	4,183	436,361			
		910,356	115,327	1,025,683	942,245	152,114	1,094,359	3.5%	31.9%	6.7%
Sep-16	Union				770,729	250,702	1,021,431			
Sep-16	Non-Union				416,387	5,671	422,058			
		915,443	80,767	996,210	1,187,116	256,374	1,443,490	29.7%	217.4%	44.9%

Duke Energy Kentucky
Case No. 2018-00261
Monthly Payroll Variance Analysis
STAFF-DR-01-034

		Monthly Budget			Monthly Actual			Variance Percent		
Date	**Employee Group**	**Regular**	**OT**	**Total**	**Regular**	**OT**	**Total**	**Regular**	**OT**	**Total**
Oct-16	Union				459,596	143,159	602,755			
Oct-16	Non-Union				416,699	1,974	418,673			
		940,239	78,863	1,019,102	876,294	145,133	1,021,427	-6.8%	84.0%	0.2%
Nov-16	Union				466,721	144,744	611,465			
Nov-16	Non-Union				418,479	2,873	421,352			
		828,583	95,642	924,225	885,200	147,617	1,032,817	6.8%	54.3%	11.7%
Dec-16	Union				501,958	208,034	709,992			
Dec-16	Non-Union				404,806	5,174	409,980			
		840,637	82,237	922,874	906,764	213,208	1,119,972	7.9%	159.3%	21.4%
YTD - 16	Union				5,806,470	1,731,346	7,537,816			
YTD - 16	Non-Union				5,063,010	31,833	5,094,843			
		10,484,041	1,003,876	11,487,917	10,869,480	1,763,179	12,632,659	3.7%	75.6%	10.0%

Variances are primarily driven by overtime hours greater than assumed in the budget and timing differences of planned work compared to the budget

Jan-17	Union				571,247	83,545	654,792			
Jan-17	Non-Union				396,959	3,978	400,937			
		948,259	118,720	1,066,979	968,206	87,524	1,055,730	2.1%	-26.3%	-1.1%
Feb-17	Union				452,005	66,116	518,121			

Duke Energy Kentucky
Case No. 2018-00261
Monthly Payroll Variance Analysis
STAFF-DR-01-034

		Monthly Budget			Monthly Actual			Variance Percent		
Date	Employee Group	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Feb-17	Non-Union				401,496	2,585	404,081			
		988,216	120,373	1,108,589	853,501	68,702	922,203	-13.6%	-42.9%	-16.8%
Mar-17	Union				674,091	109,364	783,455			
Mar-17	Non-Union				454,164	3,031	457,195			
		928,664	89,347	1,018,011	1,128,255	112,394	1,240,649	21.5%	25.8%	21.9%
Apr-17	Union				465,546	83,140	548,686			
Apr-17	Non-Union				423,664	3,058	426,722			
		954,508	162,879	1,117,387	889,211	86,198	975,409	-6.8%	-47.1%	-12.7%
May-17	Union				464,658	85,896	550,554			
May-17	Non-Union				451,686	4,164	455,850			
		1,048,734	252,193	1,300,927	916,343	90,060	1,006,403	-12.6%	-64.3%	-22.6%
Jun-17	Union				474,891	143,333	618,224			
Jun-17	Non-Union				432,633	(167)	432,466			
		960,888	159,664	1,120,552	907,524	143,166	1,050,690	-5.6%	-10.3%	-6.2%
Jul-17	Union				448,861	138,012	586,873			
Jul-17	Non-Union				434,357	3,378	437,735			
		982,962	134,352	1,117,314	883,219	141,390	1,024,609	-10.1%	5.2%	-8.3%
Aug-17	Union				484,934	160,167	645,101			
Aug-17	Non-Union				433,944	5,785	439,729			
		944,404	200,903	1,145,307	918,878	165,952	1,084,830	-2.7%	-17.4%	-5.3%

Duke Energy Kentucky
Case No. 2018-00261
Monthly Payroll Variance Analysis
STAFF-DR-01-034

		Monthly Budget			Monthly Actual			Variance Percent		
Date	Employee Group	Regular	OT	Total	Regular	OT	Total	Regular	OT	Total
Sep-17	Union				739,808	208,564	948,372			
Sep-17	Non-Union				463,937	13,202	477,139			
		964,596	116,771	1,081,367	1,203,745	221,765	1,425,510	24.8%	89.9%	31.8%
Oct-17	Union				473,626	139,746	613,372			
Oct-17	Non-Union				438,806	2,630	441,436			
		965,369	149,483	1,114,852	912,432	142,376	1,054,808	-5.5%	-4.8%	-5.4%
Nov-17	Union				467,886	128,758	596,644			
Nov-17	Non-Union				426,661	3,140	429,801			
		1,033,582	198,254	1,231,836	894,547	131,898	1,026,445	-13.5%	-33.5%	-16.7%
Dec-17	Union				411,856	139,394	551,250			
Dec-17	Non-Union				440,003	4,504	444,507			
		1,361,346	231,644	1,592,990	851,859	143,898	995,757	-37.4%	-37.9%	-37.5%
YTD - 17	Union				6,129,410	1,486,035	7,615,445			
YTD - 17	Non-Union				5,198,311	49,288	5,247,599			
		12,081,526	1,934,583	14,016,109	11,327,721	1,535,323	12,863,044	-6.2%	-20.6%	-8.2%

Variances are primarily due to to open positions, which are often backfilled by contractors, and timing differences of planned work compared to budget.

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-035

REQUEST:

Provide all wage, compensation, and employee benefits studies, analyses, or surveys conducted since Duke Kentucky's last rate case or that are currently utilized by Duke Kentucky.

RESPONSE:

Objection. This request is overbroad and unduly burdensome due to the voluminous nature of the request to the extent it requires the provision of information dating back to the Company's last natural gas rate case. Duke Energy Kentucky's last base natural gas rate case was filed in 2009. Without waiving said objection, and to the extent discoverable, Duke Energy participates in and utilizes a variety of salary surveys and ad hoc analyses conducted by third parties on an annual basis. Please refer to the direct testimony of Company witness Renee Metzler as Attachment RHM-4 contains a list of surveys being utilized in 2018. The documents are voluminous in nature and are considered to be proprietary by the vendor and subject to licensing agreements. As a result, to the extent permitted by these vendors, the Company will make available for the Commission's review, any of the surveys at a time and place that is convenient to the Commission and the Company.

In section V. of the testimony provided by Renee Metzler, the application of the survey data is described and how it directly relates to ensuring the competitiveness of the

Company's compensation programs. In addition, the results of several studies regarding annual merit increases, the attraction and retention of employees, the financial cost of turnover, short-term incentive plan design and the prevalence of long-term incentives have been included in the Direct Testimony as Attachments RHM-2, RHM-3, RHM-5(a), RHM-5(b), RHM-8 and RHM-9.

PERSON RESPONSIBLE: Renee H. Metzler

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-036

REQUEST:

For each employee group, state the amount, percentage increase, and effective date for general wage increases and, separately, for merit increases granted or to be granted in the past two calendar years, the base period, and the forecasted test period.

RESPONSE:

On page 14 of Renee Metzler's direct testimony, a chart was provided showing the merit increases provided to the various employee groups for the calendar years 2014 through 2018. Each year, these increases are effective in the pay period that contains March 1. As stated in the testimony, employees' individual increases may vary relative to the budget to allow for individual differentiators based on performance and current pay levels relative to the market. The increase awarded to each employee, if any, is based on a combination of factors, including his/her individual performance rating, his/her performance relative to his/her peers, and the position of his/her salary within the salary range for his/her job. The merit budget has not yet been determined for the forecasted test period. The Company generally waits until the fourth quarter of each year to make that determination, so the most up-to-date economic and market-based factors may be taken into consideration. However, the Company has included a placeholder of 3 percent in its budgeting plans for merit increases based on recent historical trends. On pages 15 and 16 of the testimony, the general wage increases awarded to union employees have been

articulated and may also be referenced in the labor union contracts in Attachments RHM-6 (a) through (c).

PERSON RESPONSIBLE: Renee H. Metzler

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-037

REQUEST:

Provide a schedule reflecting the salaries and other compensation of each executive officer for the base period and three most recent calendar years. Include the percentage annual increase and the effective date of each increase, the job title, duty and responsibility of each officer, the number of employees who report to each officer, and to whom each officer reports. For employees elected to executive officer status since the test year in Duke Kentucky's most recent rate case, provide the salaries for the person they replaced.

a. Provide the account numbers to which the executive officers' salaries and other compensation were charged.

b. Provide an explanation of the amount and percentage of each of these employees' salaries and associated expenses that were recorded below the line for ratemaking purposes, along with how the methodology for doing so was determined.

RESPONSE:

See STAFF-DR-01-37(a) Attachment for the list of officers and responsibilities.

See STAFF-DR-01-37(b) Attachment for prior executives and compensation and STAFF-DR-01-37(c) Attachment for schedules showing salary information and employee counts, and salary information for current executives. See STAFF-DR-01-37(d) Attachment for the account numbers and amount recorded below the line.

PERSON RESPONSIBLE: Renee H. Metzler

Duke Energy Executive Profile

Melissa H. Anderson
Executive Vice President
Administration and
Chief Human Resources Officer

Melissa Anderson serves as executive vice president, administration and chief human resources officer for Duke Energy. She is responsible for human resources policy and strategy, talent management and diversity, employee and labor relations, total rewards strategies and programs, and delivery of business partner services. Her administrative responsibilities include the real estate, land services, aviation and support services organizations.

Anderson joined Duke Energy in January 2015 from Domtar Inc., a Canada-based manufacturer of paper and personal care products. From 2010 to 2015, she served as senior vice president of human resources and corporate steward of talent for approximately 10,000 Domtar employees worldwide. She helped mold Domtar's successful evolution from a traditional pulp and paper manufacturer to an industry leader in fiber-based products, technology and services. In addition, she negotiated an innovative four-year contract with the United Steelworkers, which included the industry's first defined contribution pension plan.

Her prior corporate experience includes serving as vice president of human resources of global financing at IBM Corp. During her 17-year tenure with the Fortune 100 company, Anderson created and implemented talent strategies and led several successful cultural initiatives. She has also served as senior vice president of human resources and government relations for The Pantry Inc., from 2006 to 2010.

Anderson earned a Bachelor of Science degree in industrial relations from the University of North Carolina at Chapel Hill and a Master of Industrial and Labor Relations from Cornell University.

A native of Boone, N.C., Anderson and her husband, Daren, have a son and a daughter.

Duke Energy, one of the largest energy holding companies in the United States, supplies and delivers electric services to approximately 7.5 million customers in the Southeast and Midwest. The company also distributes natural gas services to approximately 1.6 million customers in the Carolinas, Ohio, Kentucky and Tennessee. Its commercial business operates a growing renewable energy portfolio across the United States. Headquartered in Charlotte, N.C., Duke Energy is a Fortune 125 company traded on the New York Stock Exchange under the symbol DUK.

Duke Energy Executive Profile

Andrea E. Bertone
President
Duke Energy International

Andrea Bertone is president of Duke Energy International (DEI). She leads the Duke Energy business that owns and operates power generation facilities outside North America. DEI currently owns, operates or has substantial interests in approximately 4,900 gross megawatts of installed capacity in seven different countries in Latin America, in addition to owning interest in a methanol facility in Saudi Arabia. Bertone was named for her current position in July 2009.

Previously, she served as general counsel for DEI, a position that she held since 2006 in addition to serving as a director and later, and to this date, as a board member for DEI Paranapanema, a publicly traded generation company in Brazil. Before that, she served as associate general counsel for DEI, and as assistant general counsel for Duke Energy Services. She joined Duke Energy in 2001 in Houston.

Bertone began her career as a lawyer in São Paulo, Brazil, where she had a broad experience working for the federal judiciary system, as an associate to large local law firms, as in-house counsel for an airline company, and finally establishing and managing her own law practice. She moved to the United States in the early '90s, and after working for the international law firm of Baker & McKenzie in Chicago, Ill., returned to South America where she started her career in the energy sector working for Enron International. At that time, she actively participated in the privatization of the energy sector, especially in Brazil and Argentina.

Bertone earned a Juris Doctor degree from the University of São Paulo, Brazil, and a master's degree in law from Chicago-Kent College of Law. She has also taken executive education in the area of finance at Harvard Business School.

Bertone is married to Robert and has a stepson.

Duke Energy, one of the largest electric power companies in the United States, supplies and delivers electricity to approximately 7 million customers in the Southeast and Midwest. The company also distributes natural gas in Ohio and Kentucky. Its commercial and international businesses operate diverse power generation assets in North America and Latin America, including a growing renewable energy portfolio. Headquartered in Charlotte, N.C., Duke Energy is a Fortune 125 company traded on the New York Stock Exchange under the symbol DUK.

DUKE ENERGY.

Duke Energy Executive Profile

William E. (Bill) Currens Jr.
Senior Vice President
Financial Planning and Analysis

Bill Currens serves as senior vice president of financial planning and analysis for Duke Energy. He is responsible for the business and financial planning functions of the enterprise, including oversight of the company's financial forecast. He also manages the design of policies, processes and systems that support the finance function.

Before assuming his current position in 2018, Currens served as Duke Energy's senior vice president, controller and chief accounting officer. In this role, he oversaw the accounting, financial reporting and internal controls for the corporation.

Prior to that, Currens served as vice president of investor relations, where he was responsible for managing the company's key relationships with investors and analysts, monitoring trends in the investment markets and developing investor communication materials. He has also served various roles in the controller's organization.

Prior to joining Duke Energy in October 2002, Currens spent more than nine years with the public accounting firm KPMG LLP.

A native of High Point, N.C., Currens earned a bachelor's degree in business administration and a master's degree in accounting, both from the University of North Carolina at Chapel Hill. In 2015, he completed The Executive Program at the Darden School of Business at the University of Virginia.

He is a certified public accountant in North Carolina and currently serves on the board of directors for the Renaissance West Community Initiative and the N.C. Zoological Society. He is also a member of the advisory committee for the historic Carolina Theatre in Charlotte. Currens previously served as chair of Duke Energy's United Way campaign and co-chair of the Edison Electric Institute's Investor Relations Group.

Currens and his wife, Sarah, have two daughters.

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DUKE ENERGY®

Duke Energy Executive Profile

Stephen G. De May
Senior Vice President – Tax and Treasurer

Stephen De May is senior vice president, tax and treasurer for Duke Energy. As treasurer, he is responsible for financing and capital markets activities, liability management, liquidity and cash management, long-term investments and managing Duke Energy's relationships with the major credit rating agencies. As head of tax, he is responsible for federal, state, local and international tax compliance, audits, research, structuring and tax planning, property tax, income tax accounting, tax information systems and Sarbanes-Oxley compliance with respect to tax matters.

Previously, De May served as senior vice president and treasurer, after the closing of the Progress Energy merger in 2012 until February 2016. Prior to that, he was named senior vice president, investor relations and treasurer in October 2009 where, in addition to his treasury responsibilities, he led investor relations and monitored trends in the investment markets and maintained key relationships with debt and equity investors, analysts and financial institutions.

De May joined the company in 1990 as a director of the company's former real estate development business, Crescent Resources, where he had responsibility for managing the finance and accounting functions. In 1994, he joined the company's corporate finance group, and in 1996, completed an extended risk management assignment at the company's energy trading and marketing affiliate.

Following the Duke Power/PanEnergy merger, De May managed the corporate finance group until 1999, when he was appointed vice president of business unit finance. During 2004 and 2005, he served as vice president of energy and environmental policy, the company's primarily public policy role. Immediately following the merger between Duke Energy and Cinergy in April 2006, he served as assistant treasurer and head of corporate finance. In 2007, De May was named vice president and treasurer for Duke Energy, which included oversight of the risk management function, and in February 2009 he was named treasurer and chief risk officer. Before joining Duke Energy, he served as senior tax consultant for Deloitte & Touche and tax consultant for Price Waterhouse.

De May graduated from the University of North Carolina at Chapel Hill with a Bachelor of Arts degree in political science and a Master of Business Administration degree from the McColl Graduate School of Business at Queens University of Charlotte. He is a certified public accountant in North Carolina. In 2010, he completed the Advanced Management Program at the Wharton School of the University of Pennsylvania. A native of Long Island, N.Y., De May and his wife, Linda, have three children.

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DUKE ENERGY.

Duke Energy Executive Profile

Douglas F (Doug) Esamann
Executive Vice President
Energy Solutions

President
Midwest and Florida Regions

As executive vice president of energy solutions for Duke Energy, Doug Esamann is responsible for corporate and regulatory strategy, emerging technology and the company's regulated and commercial renewable energy operations. In addition, he has responsibility for the development, marketing and sales of customer products and services, customer communications across all channels and the company's economic development efforts. As president of the Midwest and Florida regions, he has responsibility for the profit/loss, strategic direction and performance of the company's regulated electric utilities in Indiana, Ohio, Kentucky and Florida.

Previously, Esamann served as president of Duke Energy Indiana, the state's largest electric utility, serving approximately 810,000 customers in 69 of the state's 92 counties. He was responsible for the company's regulatory, governmental relations, economic development and community affairs work in Indiana. He served in that role from November 2010 until June 2015.

Prior to that, Esamann was senior vice president of corporate strategy for Duke Energy, where he led the company's strategy development and business planning efforts, including load forecasting and market fundamentals. Following the merger between Duke Energy and Cinergy in April 2006, Esamann served as group vice president of strategy and planning for Duke Energy's regulated utilities, with responsibility for integrated resource planning, environmental compliance planning, transactional support, customer market analytics, load research and renewable energy compliance.

With Cinergy, he served as senior vice president of energy portfolio strategy and management for Cinergy's commercial business unit, with responsibility for fuel management, environmental risk management, generation dispatch, power purchases and sales, portfolio analytics, load forecasting, generation asset planning, demand-side management planning and environmental compliance planning.

Esamann began his employment with Public Service Indiana (predecessor of PSI Energy) in 1979. In the course of his PSI/Cinergy career, he held a variety of leadership roles, including vice president and chief financial officer of the commercial business unit from 1999 until 2001, and president of PSI Energy from 2001 until 2004.

Esamann has been active on a number of community and industry boards. He currently serves as chairman of the board for Energy Systems Network, a nonprofit industry initiative focused on clean technology development. He is a member of the board of directors for the Electric Power Research Institute (EPRI) and serves on the advisory board for the University of Missouri Financial Research Institute. He also serves on the board of trustees for Discovery Place, a hands-on science and technology museum for visitors of all ages based in Charlotte, N.C.

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A native of Plainfield, Ind., Esamann earned a Bachelor of Science degree in accounting from Indiana University. He and his wife, Kimberly, have two daughters, a son and three granddaughters.

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DUKE ENERGY.

Duke Energy Executive Profile

Lynn J. Good
Chairman, President
and Chief Executive Officer

Lynn Good is chairman, president and chief executive officer of Duke Energy, one of America's largest electric power companies. Under her leadership, Duke Energy has intensified its focus on serving its customers and communities well today while leading the way to a safe, secure and responsible energy future.

Before becoming CEO in 2013, she served as Duke Energy's chief financial officer, and earlier led the company's commercial energy businesses during its initial development of renewable energy projects. She began her utility career in 2003 with Cincinnati-based Cinergy, which merged with Duke Energy three years later. Prior to 2003, she was a partner at two international accounting firms, including a long career with Arthur Andersen.

Fortune magazine lists Good as 11th among the "Most Powertul Women in Business" and *Forbes* magazine calls her one of "The World's 100 Most Powerful Women." In 2016, she became the first regulated utility CEO designated as a LinkedIn Influencer – an online thought-leadership program.

Under Good's leadership, Duke Energy is embracing new technologies and forward-thinking strategies that strengthen the company's environmental stewardship. In addition to developing industry-leading solutions for managing coal ash, Duke Energy has increased its investment in solar and wind facilities to $4 billion, and the company has become a top-10 U.S. wind power producer. In 2015, more than 40 percent of the company's delivered energy was produced from carbon-free sources. Duke Energy was named as one of the "Global 100 Most Sustainable Corporations" by *Corporate Knights*, while *Newsweek* listed it as one of "America's Greenest Companies."

Duke Energy has paid a quarterly cash dividend on its common stock for 90 consecutive years. In 2015, the company was listed as one of the "50 Best Companies to Work for in America" by *Business Insider* and the prior year *DailyWorth* named it as one of the "25 Best Companies for Women."

Good is a member of the Boeing board of directors and serves on its audit and finance committees. She is also a board member of the Institute of Nuclear Power Operations, serves on the executive committee of the Edison Electric Institute's board, and is part of the executive committee of the Nuclear Energy Institute. She is a member of the Business Council and the Business Roundtable. She also serves on the boards of the Bechtler Museum of Modern Art and the Foundation for the Carolinas in Charlotte. Good holds Bachelor of Science degrees in systems analysis and accounting from Miami University in Oxford, Ohio. She and her husband, Brian, live in Charlotte, N.C.

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Duke Energy Executive Profile

James P. (Jim) Henning
Senior Vice President
Customer Services

Jim Henning is senior vice president of customer services for Duke Energy. He is responsible for customer contact operations, which includes Duke Energy's call centers and online customer interactions; revenue billing and receivables; and metering services. In addition, he has responsibility for managing the relationships and services to the company's small, medium and assigned large retail customers.

Before assuming his current position in June 2018, Jim served as state president of Duke Energy's utility operations in Ohio and Kentucky. He was accountable for advancing the company's rate and regulatory initiatives, and managing the government relations, economic development and community affairs function throughout the region. He served in that role since December 2012.

Jim has more than 25 years of experience in the energy industry. He joined Duke Energy predecessor company Cinergy in 1996 and served in numerous operations, leadership and customer-facing roles. Prior to being named state president, Jim was vice president of government and regulatory affairs for Duke Energy Ohio and Duke Energy Kentucky. He also spent more than nine years leading the commercial activities of the company's regulated natural gas business in Ohio and Kentucky.

Born and raised in Ohio, Jim earned a Bachelor of Science degree in financial services from Wright State University in Dayton, Ohio, and an MBA in finance marketing from the University of South Florida in Tampa, Fla.

Jim has served as chair of REDI Cincinnati, the region's economic development initiative, and chair of the Northern Kentucky Regional Alliance. In addition, Jim was a board member of the Cincinnati USA Regional Chamber, Cintrifuse, People Working Cooperatively, ArtsWave, 3CDC and the Boy Scouts of America, Dan Beard Council. He was also a member of the Cincinnati Business Committee and the Ohio Business Roundtable, and chaired ArtsWave's 2018 Community Campaign, which raised $12.2 million.

Jim and his wife, Christine, have two children.

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Duke Energy Executive Profile

Dwight L. Jacobs
Senior Vice President, Controller and Chief Accounting Officer

As senior vice president, controller and chief accounting officer for Duke Energy, Dwight Jacobs oversees the accounting, financial reporting and internal controls for the corporation.

Before assuming his current position in June 2018, Jacobs served as senior vice president of financial planning and analysis for Duke Energy. In this role, he was responsible for the business and financial planning functions of the enterprise, including oversight of the company's financial forecast. He also managed the design of policies, processes and systems that support the finance function.

Jacobs joined the company in 2002 and served in several leadership roles. He has served as Duke Energy's chief risk officer and led a revamping of the company's enterprise risk management practices and policies. Jacobs has served as vice president of rates and regulatory strategy for Duke Energy, where he led the regulatory activity, including rate cases, in the six states and 11 jurisdictions served by the company. He has also served as utility controller and held leadership roles in corporate accounting and reporting.

Before joining the company, Jacobs was an audit and business advisory partner with Arthur Andersen in Washington, D.C., where he started his career in 1988.

The Orangeburg, S.C., native earned a Bachelor of Science degree in business administration from the University of North Carolina at Chapel Hill. He is a graduate of the Advanced Management Program at the Wharton School of Business at the University of Pennsylvania. He completed the Advanced Risk Management Program at Loyola University Chicago's Quinlan School of Business. He is also a certified public accountant.

Jacobs is a board member and former president of Communities in Schools and a member of the board of visitors for the Children's Hospital at the University of North Carolina at Chapel Hill. He has been a youth basketball coach, a teacher at Weddington United Methodist Church and a youth mentor.

He is married to the former Moira Farrell of Charlotte, N.C., and they have a daughter and a son.

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DUKE ENERGY®

Duke Energy Executive Profile

Dhiaa M. Jamil
Executive Vice President
and Chief Operating Officer

As executive vice president and chief operating officer for Duke Energy, Dhiaa Jamil is responsible for all power generation and electric transmission for the company's regulated utilities, including nuclear, fossil and hydro generation; coal ash management; environmental, health and safety; fuels and system optimization; and supply chain. In addition, he has responsibility for companywide project management and construction, and new plant development.

Jamil has 35 years of experience in the energy industry. Previously, he served as executive vice president and president of the company's regulated generation and transmission organizations. He has also served as president of Duke Energy Nuclear, where he had overall responsibility for the safe and efficient operation of the largest regulated nuclear generation fleet in the U.S.

Jamil joined Duke Power in 1981 as an engineer in the design engineering department. He held various management roles at the Oconee, McGuire and Catawba nuclear stations, including station manager and site vice president. In 2006, Jamil was named senior vice president of nuclear support. He led the organization responsible for plant support, major projects and nuclear fuel management. He was named chief nuclear officer in 2008 and chief generation officer in 2009. Following the Duke Energy/Progress Energy merger in July 2012, he was named executive vice president and chief nuclear officer before assuming the role of executive vice president and president of Duke Energy Nuclear in March 2013.

Jamil received a Bachelor of Science degree in electrical engineering from the University of North Carolina at Charlotte. He has completed the Harvard Business School Advanced Management Program and Duke Energy's technical nuclear certification program. He is also a registered professional engineer in North Carolina and South Carolina.

Jamil currently serves on the board of directors for Nuclear Electric Insurance Limited (NEIL) and is a member of the National Nuclear Training Accrediting Board and the Nuclear Energy Institute Executive Committee.

He is currently a trustee at the University of North Carolina at Charlotte and serves as chair of the Energy Production and Infrastructure Center advisory board at UNC Charlotte. He also serves as a trustee of the Duke Energy Foundation.

Jamil and his wife, Hope, have a daughter and two sons.

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DUKE ENERGY

Duke Energy Executive Profile

Julie S. Janson
Executive Vice President
External Affairs, Chief Legal Officer
and Corporate Secretary

Julie Janson is executive vice president, external affairs, chief legal officer and corporate secretary for Duke Energy. She is the primary legal advisor to Duke Energy's board of directors and senior management, and she leads the Office of the General Counsel, which includes the company's legal, corporate governance and ethics and compliance functions. In addition, Janson oversees the corporate communications, federal government affairs, strategic policy and sustainability functions, stakeholder strategy and the Duke Energy Foundation.

Previously, Janson served as president of Duke Energy's utility operations in Ohio and Kentucky, serving approximately 1 million natural gas and electric customers in southwest Ohio and approximately 230,000 customers in six Northern Kentucky counties. Having led the Ohio/Kentucky utility operations since 2008, Janson assumed her current position in December 2012.

Prior to that, she served as senior vice president of ethics and compliance, and corporate secretary for Duke Energy, a position she held since 2006. Before that, she served as corporate secretary and chief compliance officer for Cinergy Corp. She was appointed chief compliance officer in 2004 and corporate secretary in 2000.

From 1998 to 2004, Janson served as senior counsel, providing advice on general corporate, corporate governance and securities-related matters. From 1996 to 1998, Janson served as counsel for Cinergy, providing research, advice and support for divestitures, mergers and acquisitions, and several internal clients including investor relations, shareholder services, corporate communications and government and regulatory affairs. She also served as corporate counsel to the international business unit. She was manager of investor relations for Cinergy from 1995 to 1996.

Prior to joining Cinergy, Janson was corporate attorney for The Cincinnati Gas & Electric Company (CG&E), playing a role in the merger of CG&E and PSI Energy, which formed Cinergy Corp. Before joining CG&E, she served as a law clerk with Adams, Brooking, Stepner, Wolterman & Dusing in Covington, Ky.

She earned a Juris Doctor degree from the University of Cincinnati College of Law. She also holds a Bachelor of Arts degree in American Studies from Georgetown College in Georgetown, Ky.

Janson is a member of the bar associations of Ohio and Kentucky, with legal experience that spans nearly 30 years. She is a member of the DirectWomen Board Institute Class of 2011, a program designed to identify and promote accomplished female lawyers to serve on corporate boards of public companies.

Janson is active in a number of community and professional activities. She is a member of the Edison Electric Institute (EEI) Legal Committee, director of the North Carolina Chamber Legal

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Institute and vice chair of Economic Development for the Charlotte Chamber Executive Committee. She serves on the board of directors of The Ohio National Life Insurance Co. and Ohio National Financial Services Inc. and on the board of trustees for Queens University. She is also a member of the Commercial Club of Cincinnati and serves as a trustee for the Duke Energy Foundation.

Janson chaired the Cincinnati Business Committee and co-chaired the Economic Development Task Force. She chaired the board of directors and the executive committee of the Cincinnati USA Regional Chamber. She was also a member of the board of directors and executive committee of the Ohio Business Roundtable, the Kentucky Chamber of Commerce and a member of the Vision 2015 CEO Roundtable in Northern Kentucky.

Janson served on the Climate Protection Steering Committee, appointed by the Cincinnati City Council, and was a board member of the Cincinnati Center City Development Corporation (3CDC), the University of Cincinnati Foundation and Cintrifuse. She served as vice chair of the 2012 World Choir Games and chaired the city of Cincinnati's 2010 Fine Arts Fund Campaign. She has also served on the boards of directors of Northern Kentucky Tri-County Economic Development Corporation (Tri-ED), Vision 2015 Regional Stewardship Council, United Way of Greater Cincinnati and Lighthouse Youth Services.

Janson and her husband, Chip, have two daughters.

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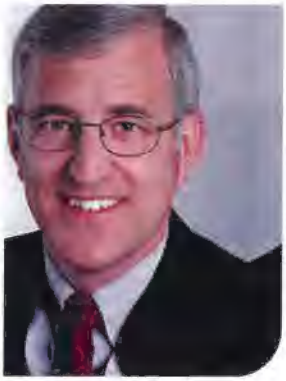
DUKE ENERGY.

Duke Energy Executive Profile



A.R. Mullinax
Executive Vice President
Strategic Services

A.R. Mullinax serves as executive vice president of strategic services for Duke Energy. He leads the information technology, supply chain, administrative services and performance excellence functions that deliver services across the company.

Previously, he served as vice president, information technology, and chief information officer for Duke Energy. During 2011, he served as Duke Energy's integration executive, with responsibility for the planning of integration activities for the Duke Energy/Progress Energy merger.

Mullinax's career began with the internal audit staff for Texas Eastern Corp. in 1977, a predecessor company of Duke Energy. He served as senior analyst of corporate planning beginning in 1980, and later served as supervisor with the company's National Methanol Co. in Saudi Arabia from 1982 to 1984. After returning to the United States, Mullinax progressed through the accounting function and was named controller in 1991. He was named general manager of management information systems and controls in 1994, and vice president of information services and controls in 1995.

Mullinax became senior vice president of Duke Energy's shared services in 1997 and held various responsibilities, including shared services, global sourcing and logistics, eBusiness and DukeNet Communications before being named vice president and chief information officer in 2004.

A native of Cameron, Texas, Mullinax received a Bachelor of Business Administration degree in accounting from Texas A&M University. He is a member of the American Institute of Certified Public Accountants and the Texas Society of Certified Public Accountants.

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Duke Energy Executive Profile

Brian D. Savoy
Senior Vice President
Business Transformation
and Technology

Brian Savoy is senior vice president, business transformation and technology for Duke Energy. He is responsible for information technology and leading business change to advance the company's strategic objectives.

Prior to this role, he served as chief accounting officer and controller for Duke Energy where his responsibilities included the accounting, financial reporting and internal controls for the corporation.

Savoy joined Duke Energy in 2001 as a manager in Duke Energy's energy trading unit, Duke Energy North America. He was named director of trading and risk services later in that year. Savoy led derivative accounting and trading control functions for energy trading and marketing activities and was instrumental in the successful wind-down and disposition of Duke Energy North America in 2005.

Following Duke Energy's merger with Cinergy in 2006, he was appointed as vice president and controller of the commercial power segment and responsible for accounting, financial reporting and internal controls functions. In 2009, Savoy was named director of forecasting and analysis where he played a significant role in addressing challenging business and strategic issues, including leading financial due diligence for the Duke Energy/Progress Energy merger completed in 2012. He assumed his current position in May 2016.

Prior to joining Duke Energy, Savoy was a manager with the international accounting firm, Deloitte & Touche where he oversaw audit engagements for large energy clients.

Savoy earned a Bachelor of Business Administration degree in accounting from Lamar University in Beaumont, Texas and completed the Advanced Management Program at the Fuqua School of Business at Duke University in Durham, N.C. He is a certified public accountant in both Texas and Ohio.

Savoy currently serves on the boards of advisors for the Belk College of Business at UNC Charlotte and the McColl School of Business at Queens University. He and his wife, Sabrina, along with their son and daughter, live in Charlotte, N.C.

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DUKE ENERGY

Duke Energy Executive Profile

Amy B. Spiller
State President
Ohio and Kentucky

Amy Spiller is president of Duke Energy's utility operations in Ohio and Kentucky, which serves approximately 850,000 electric customers and 533,000 natural gas customers. She is accountable for advancing the company's rate and regulatory initiatives, and managing the government relations, economic development and community affairs functions throughout the region.

Prior to assuming her current role in June 2018, Amy was vice president of government and community affairs for Duke Energy Ohio. In this role, she was responsible for state government and regulatory policies, strategies and relationships impacting Duke Energy Ohio's interests and those of its electric and natural gas customers. Amy also led the company's local community relations efforts with key stakeholders in southwest Ohio.

Amy previously spent 10 years as deputy general counsel, where she helped shape and guide Duke Energy's regulatory strategic planning in Ohio and Kentucky. She was also responsible for advancing the company's rate and regulatory initiatives before the Kentucky Public Service Commission and Public Utilities Commission of Ohio. Amy joined Cinergy, a predecessor to Duke Energy, in 2003 as an associate general counsel focused on litigation.

From 1993 to 2003, she rose from associate to partner at an insurance defense law firm in Cincinnati. Amy previously worked for a legal publishing company in northeast Ohio. She is a member of the Ohio and Kentucky bar associations and admitted to a variety of federal courts, including the United States Supreme Court.

Amy serves on the board of directors of Red Bike, Cincinnati's nonprofit bike-share system, the Cincinnati Regional Business Committee, the Northern Kentucky Regional Alliance and REDI Cincinnati, the region's economic development initiative. She is also a member of the Cincinnati USA Regional Chamber of Commerce's government affairs executive committee and the board of managers of the Cincinnati Center City Development Corp. Amy is a past board member of Accountability and Credibility Together and the Cincinnati Youth Collaborative, and was a member of the steering committee for the Greater Cincinnati Minority Counsel Program. She is a graduate of the Cincinnati Chamber of Commerce's WE Lead program and, in 2015, Amy was inducted into the Hall of Fame of Duke Energy's Business Women's Network employee resource group in Cincinnati.

A native of northern Michigan, Amy earned a bachelor's degree in economics and management from Albion College in Michigan and a law degree from Wake Forest University in Winston-Salem, N.C. She and her husband, Keith, have lived in Cincinnati for 25 years.

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DUKE ENERGY®

Duke Energy Executive Profile

Jennifer L. Weber
Executive Vice President
External Affairs and Strategic Policy

As executive vice president of external affairs and strategic policy for Duke Energy, Jennifer Weber leads the federal affairs, public affairs, environmental and energy policy, corporate communications and sustainability functions. Her communications responsibilities include strategy and services: support for the company's businesses, brand management, media relations, social media and Web presence. In addition, Jennifer has responsibility for The Duke Energy Foundation and community affairs.

Previously, Jennifer served as executive vice president and chief human resources officer for Duke Energy, where she led the human resources and communications functions. This included human resources policy and strategy, talent management and diversity, employee and labor relations, total rewards strategies and programs, and delivery of business partner services. In addition, Jennifer had responsibility for the administrative services function, which included aviation, enterprise protective services, real estate, support services and land services.

Jennifer joined Duke Energy in November 2008 from Scripps Networks Interactive Inc. in Cincinnati, Ohio. From 2005 to 2008, she served Scripps, and then Scripps Networks Interactive when the company was spun off, as senior vice president of human resources. Prior to joining Scripps in 2005, Jennifer worked at the consulting firm Towers Perrin for 12 years – as a partner and as managing principal of the firm's Cincinnati office. In that role, she participated in the design and implementation of total rewards strategies and programs for many large clients.

A native of Mansfield, Ohio, Jennifer received a master's degree from Carnegie Mellon University. She also earned a bachelor's degree from Miami University in Ohio, graduating Phi Beta Kappa and cum laude.

Jennifer is a past chair and current member of the board of directors for the United Way of Central Carolinas. She is also a member of the executive committee of the Charlotte Chamber, national advisory board of the Institute for Emerging Issues and the board of directors for the Center for Climate and Energy Solutions. Prior to her relocation to Charlotte, she served on the boards of the Dan Beard Boy Scout Council of Greater Cincinnati and the Salvation Army. She also participated in Leadership Cincinnati. Jennifer and her husband, Eric, have two daughters and a son.

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Duke Energy Executive Profile

Gregory C. (Greg) Wolf
President
Commercial Portfolio
and Duke Energy Renewables

Greg Wolf is president of Duke Energy's commercial portfolio and also serves as president of Duke Energy Renewables. The commercial portfolio consists of the company's nonregulated renewable energy, electric transmission, natural gas infrastructure and energy storage businesses. He assumed his current position in June 2015.

For the past five years, Greg has focused on growing and managing Duke Energy's utility-scale wind and solar generation assets, which total more than 2,000 megawatts across 12 states. Customers include utilities, electric cooperatives, municipalities, large corporations and leading universities.

Duke Energy added controlling investments in REC Solar and Phoenix Energy Technologies to its growing commercial business in 2015, expanding its offerings to include distributed solar projects, energy storage systems and energy management solutions specifically tailored for small and mid-size businesses to large organizations and corporations.

Previously, Greg has managed energy technology investments for Duke Energy and led the company's commercial telecommunications business. Before the Duke Energy/Cinergy merger in 2006, he served as vice president for generation management in Cinergy's commercial business unit. His experience prior to Duke Energy included executive roles at General Electric, where he managed energy investments for GE Capital and led business development for GE Power Systems. He began his career at Procter & Gamble with roles in marketing.

Greg earned undergraduate degrees in industrial management and finance from the University of Cincinnati and a Master of Business Administration degree from the Harvard Business School.

Greg currently serves on the boards of Semprius, a unique high concentration photovoltaic company, and Northern Power Systems (NPS, TSX), a wind turbine and power technology company.

In the community, he serves on the governing board of the Carolina Thread Trail, an interconnected trail system in piedmont North Carolina and South Carolina focused on preserving natural corridors. He is on the board of trustees for the University of Cincinnati Foundation and previously served as a trustee on the Cincinnati Museum Center Board.

He and his family reside in Charlotte, N.C.

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Duke Energy Executive Profile

Lloyd M. Yates
Executive Vice President
Customer and Delivery Operations

President
Carolinas Region

As executive vice president of customer and delivery operations for Duke Energy, Lloyd Yates is responsible for all customer-facing operations. In addition, he oversees the company's electric distribution system, as well as planning for grid investments to enhance reliability and the customer experience. As president of Duke Energy's Carolinas Region, he has responsibility for the profit/loss, strategic direction and performance of the company's regulated utilities in North Carolina and South Carolina.

Yates has more than 30 years of experience in the energy industry, including the areas of nuclear generation, fossil generation and energy delivery. He previously served as executive vice president of regulated utilities for Duke Energy, where he had responsibility for the company's utility operations in six states. He also had responsibility for federal government affairs, as well as environmental and energy policy at the state and federal levels. As executive vice president of customer operations for Duke Energy, he led the transmission, distribution, customer services, gas operations and grid modernization functions to approximately 7.2 million electric customers and 500,000 natural gas customers.

Prior to the Duke Energy/Progress Energy merger in July 2012, Yates served as president and chief executive officer for Progress Energy Carolinas. He was promoted to that position in July 2007, after serving for more than two years as senior vice president of energy delivery for Progress Energy Carolinas. Prior to that, he served as vice president of transmission for Progress Energy Carolinas. Yates joined Progress Energy predecessor, Carolina Power & Light, in 1998, and served for five years as vice president of fossil generation. Before joining Progress Energy, he worked for PECO Energy for 16 years in several line operations and management positions.

Yates earned a bachelor's degree in mechanical engineering from the University of Pittsburgh and a master's degree in business administration from St. Joseph's University in Philadelphia. He attended the Advanced Management Program at the University of Pennsylvania Wharton School and the Executive Management Program at the Harvard Business School.

Yates serves on several community, state and industry boards. In 2014, he was elected president and chairman of the Association of Edison Illuminating Companies. He is also a director for Marsh & McLennan Companies Inc., a global professional services firm. Yates and his wife, Monica, have two daughters.

Duke Energy, one of the largest energy holding companies in the United States, supplies and delivers electric services to approximately 7.5 million customers in the Southeast and Midwest. The company also distributes natural gas services to approximately 1.6 million customers in the Carolinas, Ohio, Kentucky and Tennessee. Its commercial business operates a growing renewable energy portfolio across the United States. Headquartered in Charlotte, N.C., Duke Energy is a Fortune 125 company traded on the New York Stock Exchange under the symbol DUK.

Duke Energy Executive Profile

Franklin H. (Frank) Yoho
Executive Vice President and President
Natural Gas Business

As executive vice president and president of Duke Energy's natural gas business, Frank Yoho oversees all of the company's natural gas operations in North Carolina, South Carolina, Ohio, Kentucky and Tennessee.

Prior to Duke Energy's acquisition of Piedmont Natural Gas in October 2016, Yoho served as senior vice president and chief commercial officer for Piedmont Natural Gas. In this role, he was responsible for sales and marketing, transportation services, supply planning, gas supply, wholesale marketing, field customer service and customer service.

Before joining Piedmont in 2002, Yoho served as vice president of business development for CT Communications and senior vice president, marketing and gas supply, for the former Public Service Company of North Carolina (PSNC), now a division of SCANA Corporation.

Yoho received his MBA from Ohio State University and a bachelor's degree in economics from Washington and Jefferson College.

Yoho serves as board chair of the Southern Gas Association and is a member of the advisory board for the Energy Production and Infrastructure Center (EPIC) at UNC Charlotte. He has served as first vice president of the Southeastern Gas Association and was formerly on the board of trustees of the Institute of Gas Technology.

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DUKE ENERGY.

Duke Energy Executive Profile

Steven K. Young
Executive Vice President
and Chief Financial Officer

Steve Young is executive vice president and chief financial officer for Duke Energy. He leads the financial function, which includes the controller's office, treasury, tax, risk management and insurance, as well as corporate development. These duties include accounting, cash management and overseeing risk control policies. Young also oversees the company's information technology, cybersecurity and physical security organizations.

Young joined Duke Power in 1980 as a financial assistant. After a series of promotions within the controller's department, he was named manager of bulk power agreements in system planning and operating in 1991, and manager of the rate department in 1993. In April 1998, Young was appointed vice president of rates and regulatory affairs, with responsibility for Duke Power's regulatory strategies and policies in rate, financial and accounting matters. He was also accountable for the company's interaction with the utility commissions of North Carolina and South Carolina, and the Federal Energy Regulatory Commission. He was named senior vice president and chief financial officer for Duke Power in February 2003, group vice president and chief financial officer in March 2004, and vice president and controller in June 2005.

In December 2006, Young was named senior vice president and controller for Duke Energy. In addition to maintaining that role at the close of the merger between Duke Energy and Progress Energy in July 2012, he also became the company's chief accounting officer. He was named executive vice president and chief financial officer of Duke Energy in August 2013. In early 2016, Young also assumed responsibility for Duke Energy's newly formed business transformation and technology function.

Young earned a Bachelor of Arts degree in business administration from the University of North Carolina at Chapel Hill. He also completed the Advanced Management Program at the Wharton School of Business and the Reactor Technology Course for Utility Executives at the Massachusetts Institute of Technology.

Young is a certified public accountant and a certified managerial accountant in North Carolina. He is a member of the American Institute of Certified Public Accountants, Institute of Managerial Accountants and National Association of Accountants. He is also a member of the Edison Electric Institute CFO Committee. Young serves as a member of the boards of directors for the Bechtler Museum of Art and the Charlotte Sports Foundation. He is also a member of the Regional Campaign Committee of the United Way of Central Carolinas.

Young was born in 1958. He and his wife, Lilly, have a daughter and a son.

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DUKE ENERGY®

Duke Energy, one of the largest energy holding companies in the United States, supplies and delivers electric services to approximately 7.5 million customers in the Southeast and Midwest. The company also distributes natural gas services to approximately 1.6 million customers in the Carolinas, Ohio, Kentucky and Tennessee. Its commercial business operates a growing renewable energy portfolio across the United States. Headquartered in Charlotte, N.C., Duke Energy is a Fortune 125 company traded on the New York Stock Exchange under the symbol DUK.

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Previous Executive Officers

Name	Title	Annual Rate as of Last Date in Role	Last Date in Role	Notes
B Keith Trent	EVP, Grid Solutions and President, MW and FL Regions	$615,000	5/31/2015	
Brett C Carter	SVP, Chief Distribution Officer	$330,000	8/15/2014	As reflected on the 2013 FERC Form 1
Christopher C Rolfe	Group Executive & Chief Administrative Officer	$399,996	6/1/2009	
David L Hauser	Group Executive & Chief Financial Officer	$600,000	7/1/2009	
James E Mehring	VP, Gas Operations	$247,164	5/1/2014	
James E Rogers	Chairman, Pres & CEO	$0	6/30/2013	Paid through stock
James L Turner	Group Executive, Pres & COO of US FEG	$650,004	1/1/2011	
Jeana G Sheehan	Interim Chief HR Officer	$350,000	3/1/2015	
Jeffrey J Lyash	EVP, Energy Supply	$515,000	1/1/2013	
Jim L Stanley	SVP & Chief Distribution Officer	$329,333	10/1/2012	
Julia S Janson	State President OH/KY	$322,250	12/16/2012	As reflected on the 2011 FERC Form 1
Lynn J Good	EVP & Chief Financial Officer	$625,000	6/30/2013	As reflected on the 2011 FERC Form 1
Marc Manly	Group Executive & Chief Legal Officer & Corporate Secretary	$600,000	12/16/2012	
Patricia K Walker	SVP, OH and KY Gas Operations	$243,870	6/1/2010	
Sandra P Meyer	SVP, Power Delivery	$349,176	6/1/2010	
Steven K Young	VP, Chief Accounting Officer & Controller	$324,225	8/5/2013	As reflected on the 2012 FERC Form 1

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Executive Officer Job History

Anderson,Melissa H.

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2018	EVP, Administration&ChiefHROff	2.50%	$522,596	80%	150%	570	Good,Lynn J
3/1/2017	EVP, Administration&ChiefHROff	10.00%	$509,850	80%	150%	515	Good,Lynn J
5/1/2016	EVP, Administration&ChiefHROff	3.00%	$463,500	80%	150%	542	Good,Lynn J
3/1/2016	SVP&ChiefHumanResourcesOff	5.88%	$450,000	80%	150%	252	Good,Lynn J
1/1/2016	SVP&ChiefHumanResourcesOff		$425,000	80%	150%	260	Good,Lynn J
3/1/2015	SVP&ChiefHumanResourcesOff		$425,000	70%	150%	259	Good,Lynn J

Bertone,Andrea E

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2016	President Duke Energy Intl	2.50%	$367,921	55%	90%	839	Young,Steven K
3/1/2015	President Duke Energy Intl	2.25%	$358,947	55%	90%	911	Manly,Marc E

Currens Jr,William E

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
6/1/2018	SVP Financial Planning & Analysis		$330,842	50%	95%	258	Young,Steven K
3/1/2018	SVP ChiefAcctingOff&Controller	8.15%	$330,842	50%	95%	217	Young,Steven K
1/1/2018	SVP ChiefAcctingOff&Controller		$305,910	50%	95%	217	Young,Steven K
3/1/2017	SVP ChiefAcctingOff&Controller	10.00%	$305,910	50%	90%	220	Young,Steven K
3/1/2017	SVP ChiefAcctingOff&Controller	3.00%	$278,100	50%	90%	220	Young,Steven K
1/1/2017	SVP ChiefAcctingOff&Controller		$270,000	50%	90%	223	Young,Steven K
5/16/2016	SVP ChiefAcctingOff&Controller	17.68%	$270,000	50%	80%	317	Young,Steven K
3/1/2016	VP Investor Relations	3.00%	$229,446	40%	60%	15	Young,Steven K
3/1/2015	VP Investor Relations	5.50%	$222,763	40%	60%	16	Young,Steven K

De May,Stephen G

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2018	SVP, Tax and Treasurer	4.00%	$387,367	50%	85%	71	Young,Steven K
1/1/2018	SVP, Tax and Treasurer		$372,468	50%	85%	74	Young,Steven K
3/1/2017	SVP, Tax and Treasurer	4.00%	$372,468	50%	80%	80	Young,Steven K
3/1/2016	SVP, Tax and Treasurer	5.00%	$358,143	50%	80%	84	Young,Steven K
3/1/2016	SVP, Tax and Treasurer	3.00%	$341,088	50%	80%	84	Young,Steven K
2/1/2016	SVP, Tax and Treasurer		$331,154	50%	80%	21	Young,Steven K
3/1/2015	SVP Treasurer	3.00%	$331,154	45%	75%	20	Young,Steven K

Esamann,Douglas F

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2018	EVP Energy Slns & Pres MW FL	7.00%	$625,950	80%	225%	1,198	Good,Lynn J
3/1/2017	EVP Energy Slns & Pres MW FL	17.00%	$585,000	80%	225%	1,090	Good,Lynn J
1/1/2017	EVP Energy Slns & Pres MW FL		$500,000	80%	225%	1,082	Good,Lynn J
3/1/2016	EVP & Pres, MW & FL Regions	11.11%	$500,000	80%	200%	3,111	Good,Lynn J
1/1/2016	EVP & Pres, MW & FL Regions		$450,000	80%	200%	3,111	Good,Lynn J
6/1/2015	EVP & Pres, MW & FL Regions	18.88%	$450,000	70%	150%	2,791	Good,Lynn J
3/1/2015	State President-IN	3.00%	$378,540	45%	75%	35	Trent,B Keith

Good,Lynn J

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2017	Chairman, President & CEO	3.85%	$1,350,000	155%	750%	28,925	
1/1/2017	Chairman, President & CEO		$1,300,000	155%	750%	28,719	
3/1/2016	Chairman, President & CEO	4.00%	$1,300,000	150%	700%	27,698	
1/1/2016	Chairman, President & CEO		$1,250,000	150%	700%	27,750	
6/25/2015	Pres, CEO & Vice Chair of BOD	4.17%	$1,250,000	140%	600%	27,607	
3/1/2015	Pres, CEO & Vice Chair of BOD		$1,200,000	125%	450%	27,281	

Henning,James P

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
6/1/2018	SVP Customer Services	9.00%	$330,000	45%	75%	2,313	Yates,Lloyd Marques
3/1/2018	State President-OH/KY	2.50%	$302,732	45%	75%	23	Esamann,Douglas F
3/1/2017	State President-OH/KY	5.00%	$295,348	45%	75%	22	Esamann,Douglas F
11/1/2016	State President-OH/KY	5.00%	$281,284	45%	75%	22	Esamann,Douglas F
3/1/2016	State President-OH/KY	2.50%	$267,890	45%	75%	24	Esamann,Douglas F
3/1/2015	State President-OH/KY	4.00%	$261,356	45%	75%	25	Trent,B Keith
1/1/2015	State President-OH/KY		$251,304	45%	75%	24	Trent,B Keith

Jacobs, Dwight L

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
6/1/2018	SVP Chief Accounting Officer & Controller		$311,881	45%	75%	216	Young,Steven K
3/1/2018	SVP Financial Planning & Analysis	4.50%	$311,881	45%	75%	258	Young,Steven K
3/1/2017	SVP Financial Planning & Analysis	7.12%	$298,451	45%	75%	242	Young,Steven K
3/1/2016	SVP Financial Planning & Analysis	5.06%	$278,614	45%	75%	269	Young,Steven K
3/1/2015	SVP Global Risk Mgmt &Insurance & CRO	3.20%	$265,189	45%	75%	41	Young,Steven K

Jamil,Dhiaa M

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2018	EVP & Chief Operating Officer	2.50%	$807,188	80%	275%	14,543	Good,Lynn J
3/1/2017	EVP & Chief Operating Officer	5.00%	$787,500	80%	275%	14,627	Good,Lynn J
3/1/2016	EVP & Pres, Generation&Transm	11.11%	$750,000	80%	275%	14,216	Good,Lynn J
1/1/2016	EVP&Pres,Regulated Generation		$675,000	80%	275%	14,292	Good,Lynn J
3/1/2015	EVP&Pres,Regulated Generation	3.85%	$675,000	80%	250%	11,767	Good,Lynn J
1/1/2015	EVP&Pres,Regulated Generation		$650,000	80%	250%	11,689	Good,Lynn J

Janson,Julia Smoot

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2018	EVP Ext Affairs,CLO & Corp Sec	2.50%	$640,625	80%	225%	333	Good,Lynn J
5/1/2017	EVP Ext Affairs,CLO & Corp Sec		$625,000	80%	225%	330	Good,Lynn J
3/1/2017	EVP & Chief Legal Officer	19.05%	$625,000	80%	225%	326	Good,Lynn J
3/1/2016	EVP & Chief Legal Officer	5.00%	$525,000	80%	225%	364	Good,Lynn J
1/1/2016	EVP & Chief Legal Officer		$500,000	80%	225%	170	Good,Lynn J
3/1/2015	EVP & Chief Legal Officer		$500,000	80%	200%	243	Good,Lynn J
1/1/2015	EVP & Chief Legal Officer		$500,000	80%	200%	242	Good,Lynn J

Mullinax,Alva Ray

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2016	EVP, Strategic Services		$450,000	70%	150%	3,078	Good,Lynn J
3/1/2015	EVP, Strategic Services		$450,000	70%	150%	2,996	Good,Lynn J

Savoy,Brian D

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2018	SVP, Bus Transformation & Tech	4.50%	$384,038	50%	95%	1,693	Young,Steven K
3/1/2017	SVP, Bus Transformation & Tech	5.00%	$367,500	50%	95%	1,594	Young,Steven K
3/1/2016	SVP ChiefAcctingOff&Controller	25.00%	$350,000	50%	95%	323	Young,Steven K
1/1/2016	SVP ChiefAcctingOff&Controller		$280,000	50%	95%	319	Young,Steven K
3/1/2015	SVP ChiefAcctingOff&Controller	2.51%	$280,000	50%	90%	328	Young,Steven K
3/1/2015	SVP ChiefAcctingOff&Controller	2.00%	$273,156	50%	90%	328	Young,Steven K
1/1/2015	SVP ChiefAcctingOff&Controller		$267,800	50%	90%	332	Young,Steven K

Spiller, Amy

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
6/1/2018	State President-OH/KY	15.00%	$267,375	45%	60%	22	Esamann,Douglas F
3/1/2018	VP Government & Community Affairs	3.33%	$232,500	35%	40%	7	Henning,James P
1/16/2018	VP Government & Community Affairs	2.41%	$225,000	35%	40%	7	Henning,James P
3/1/2017	Deputy General Counsel	2.50%	$219,704	35%	40%	3	Glenn,Robert Alexander
3/1/2016	Deputy General Counsel	2.50%	$214,346	35%	40%	3	Ghartey-Tagoe,Kodwo
3/1/2015	Deputy General Counsel	3.25%	$209,118	35%	40%	3	Ghartey-Tagoe,Kodwo

Weber,Jennifer L

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2015	EVP,Ext Affrs & Strtgc Policy		$505,000	80%	175%	158	Good,Lynn J

Wolf,Gregory C

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2016	President Commercial Portfolio	3.00%	$370,882	50%	95%	364	Good,Lynn J
6/1/2015	President Commercial Portfolio	5.00%	$360,080	50%	95%	309	Good,Lynn J
3/1/2015	President DE Renewables	4.00%	$342,933	45%	75%	264	Manly,Marc E

Yates,Lloyd Marques

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2018	EVP Cust&Delivery Ops&Pres Car	2.50%	$703,921	80%	225%	8,396	Good,Lynn J
3/1/2017	EVP Cust&Delivery Ops&Pres Car	3.00%	$686,753	80%	225%	8,078	Good,Lynn J
3/1/2016	EVP Mkt Sol & Pres,Carolinas	5.00%	$666,750	80%	225%	5,814	Good,Lynn J
3/1/2015	EVP Mkt Sol & Pres,Carolinas	3.25%	$635,000	80%	225%	4,914	Good,Lynn J

Yoho,Frank

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2018	EVP & President, Natural Gas	5.00%	$514,500	75%	150%	1,880	Good,Lynn J

1/1/2018	EVP & President, Natural Gas		$490,000	75%	150%	1,872	Good,Lynn J
10/3/2016	EVP & President, Natural Gas	4.88%	$490,000	65%	150%	1,922	Good,Lynn J
10/2/2016	SVP, Chief Commercial Officer		$467,180	61%	75%	1,922	Good,Lynn J

Young,Steven K

Effective Date	Job Title	Change Percent	Annual Rate	STI Target %	LTI Target %	# Direct Reports	Reports To
3/1/2018	EVP & CFO	2.44%	$710,325	80%	225%	2,521	Good,Lynn J
3/1/2017	EVP & CFO	10.00%	$693,000	80%	225%	2,395	Good,Lynn J
3/1/2016	EVP & CFO	5.00%	$630,000	80%	225%	824	Good,Lynn J
3/1/2015	EVP & CFO	9.09%	$600,000	80%	225%	787	Good,Lynn J

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Executive Officers

	Name	Employee ID
1	Melissa Anderson	443862
2	Andrea Bertone	226341
3	William E Currens, Jr	238445
4	Stephen G DeMay	101537
5	Douglas F Esamann	011522
6	Lynn J Good	025569
7	Franklin H Yoho	461041
8	James P Henning	018749
9	Dhiaa M Jamil	128914
10	Julia S Janson	041671
11	A R Mullinax	200048
12	Brian D Savoy	226037
13	Jennifer L Weber	274983
14	Gregory C Wolf	019097
15	Lloyd M Yates	330850
16	Steven K Young	102646
17	Dwight Jacobs	236865
18	Amy Spiller	025577

	Name	Employee ID	2018 Account #'s Charged	2017 Account #'s Charged	2016 Account #'s Charged	2015 Account #'s Charged	Below the Line?	
1	Melissa Anderson	443862	238000	238000	238000	238000	No	
			242460	242460	242460	804210	No	
			804210	804210	804220	804220	No	
			804220	804220	920000	920000	No	
			920000	920000	926000	926000	No	
				926000			No	
2	Andrea Bertone	226341	238000	238000	238000	238000	No	
				242215	242460	242461	No	
				242216	804220	804210	No	
				242460	920000	804220	No	
					926000	920000	No	
						926000	No	
3	William E Currens, Jr	238445	238000	238000	238000	238000	No	
			242460	242460	242460	242461	No	
			804220	804210	804210	804210	No	
			920000	804220	804220	804220	No	
			926000	804290	920000	920000	No	
				920000	926000	921100	No	
				926000		926000	No	
4	Stephen G DeMay	101537	238000	238000	238000	238000	No	
			242461	242460	242460	804210	No	
			804210	804210	804210	804220	No	
			804220	804220	804220	920000	No	
			920000	920000	920000		No	
				926000	926000		No	
5	Douglas F Esamann	011522	238000	238000	238000	238000	No	
			242460	242460	242460	242461	No	
			804210	804210	804210	426540	Yes	Club dues cost of $569 was noted as charged to this account in 2015.
			804220	804220	804220	804210	No	
			920000	804330	920000	804220	No	
				920000	926000	804290	No	
					930250	920000	No	

Name	Employee ID	2018 Account #'s Charged	2017 Account #'s Charged	2016 Account #'s Charged	2015 Account #'s Charged	Below the Line?
					926000	No
					930250	No

	Name	Employee ID	2018 Account #'s Charged	2017 Account #'s Charged	2016 Account #'s Charged	2015 Account #'s Charged	Below the Line?	
6	Lynn J Good	025569	238000	238000	238000	238000	No	
			242460	242460	242460	242461	No	
			804210	804210	804210	804210	No	
			804220	804220	804220	804220	No	
			920000	920000	804330	920000	No	
			926000	926000	920000	926000	No	
					926000		No	
7	Franklin H Yoho	461041	238000	920000	920000		No	
			242460	902000	902000		No	
			804210	186120	186120		No	
			804220				No	
			920000				No	
			926000				No	
8	James P Henning	018749	238000	238000	238000	238000	No	
			242460	242460	242460	242461	No	Lobbying cost of $351,066 was noted as charged to this account in 2015.
			426400	426400	426400	426540	Yes	Lobbying cost of $39,185 was noted as charged to this account in 2016.
			804210	426540	426540	804210	Yes	Lobbying cost of $183,879 was noted as charged to this account in 2017.
			804220	804210	804210	804220	No	Lobbying cost of $79,508 was noted as charged to this account in 2018.
			920000	804220	804220	804290	No	
				920000	920000	920000		
9	Dhiaa M Jamil	128914	238000	238000	238000	238000	No	
			242460	242460	242460	242461	No	
			804210	804210	804210	804210	No	
			804220	804220	804220	804220	No	
			920000	920000	920000	920000	No	
						926000	No	
10	Julia S Janson	041671	238000	238000	238000	238000	No	
			242460	242460	242460	242461	No	
			804210	804210	804210	804210	No	
			804220	804220	804220	804220	No	
			804290	920000	804290	804290	No	
			920000		920000	920000	No	
			926000			926000	No	
11	A R Mullinax	200048	238000	242460	238000	238000	No	
					242460	242461	No	
					242490	804210	No	
					804210	804220	No	
					804220	920000	No	
					920000	926000	No	
					926000		No	
12	Brian D Savoy	226037	238000	238000	238000	238000	No	
			242460	242460	242460	242461	No	
			804220	804210	804210	804210	No	
			920000	804220	804220	804220	No	
				920000	920000	920000	No	
					926000		No	

	Name	Employee ID	2018 Account #'s Charged	2017 Account #'s Charged	2016 Account #'s Charged	2015 Account #'s Charged	Below the Line?	
13	Jennifer L Weber	274983			238000	238000	No	
					242460	242461	No	
					242490	804210	No	
					804210	804220	No	
					804220	804330	No	
					920000	920000	No	
						926000	No	
14	Gregory C Wolf	019097			238000	238000	No	
					242460	242461	No	
					242490	804220	No	
					804210	920000	No	
					804220	926000	No	
					920000		No	
					926000		No	
15	Lloyd M Yates	330850	238000	238000	238000	238000	No	
			242460	242460	242460	242461	No	
			804210	804210	804210	804210	No	
			804220	804220	804220	804220	No	
			804330	804330	920000	804290	No	
			920000	920000	926000	920000	No	
			926000	926000		926000	No	
						930250	No	
16	Steven K Young	102646	238000	238000	238000	238000	No	
			242460	242460	242460	242461	No	
			804210	804210	804210	804210	No	
			804220	804220	804220	804220	No	
			920000	920000	920000	920000	No	
				926000	926000	926000	No	
17	Dwight Jacobs	236865	238000	238000	238000	238000	No	
			242460	242460	242460	242461	No	
			804210	804210	804210	804210	No	
			804220	804220	804220	804220	No	
			804290	920000	804290	804290	No	
			804330		920000	920000	No	
			920000			926000	No	
18	*Amy Spiller	025577	238000	238000	238000	238000	No	
			242460	242460	242460	242461	No	
			426400	804210	804210	804210	Yes	Lobbying cost of $99,574 was noted as charged to this account in 2018.
			804210	804220	804220	804220	No	
			804220	920000	804330	903000	No	
			920000		920000	920000	No	

*A. Spiller assumed the role of James P. Henning effective 6/1/2018

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-038

REQUEST:

Describe in detail how the base period capitalization rate was determined. If different rates were used for specific expenses (i.e., payroll, clearing accounts, depreciation, etc.), indicate the rate and how it was determined. Indicate all proposed changes to the capitalization rate and how the changes were determined.

RESPONSE:

For the actual months (Dec 2017 through May 2018) during the base period, labor is charged directly to expense or capital as deemed appropriate at that time. Any labor loadings (e.g., payroll taxes, clearing accounts, depreciation, etc.) on the direct labor cost is allocated to capital or expense based on the same proportion as the direct labor.

For the forecasted months (June 2018 through November 2018) of the base period, labor is budgeted directly to expense or capital as was deemed appropriate at the time the budget was developed (summer/fall 2017). Any labor loadings (e.g., payroll taxes, clearing accounts, depreciation, etc.) on the direct labor cost is allocated to capital or expense based on the same proportion as the direct labor.

The Company does not anticipate any changes to the capitalization rate.

PERSON RESPONSIBLE: Robert H. "Beau" Pratt
Michael Covington

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-039

REQUEST:

Provide all current labor contracts and the most recent labor contracts previously in effect.

RESPONSE:

Please see Attachments RHM-6 (a) through (c) to the Direct Testimony of Renee Metzler:

- UWUA Contract 2015 – 2019
- UWUA Sidebar letters 2015 – 2019
- USW 12049 & 5541-06 Contract and Sidebar letter 2016 – 2021

PERSON RESPONSIBLE: Renee H. Metzler

Duke Energy Kentucky
Case No. 2018-00261
Staff First Set Data Requests
Date Received: August 24, 2018

STAFF-DR-01-040

REQUEST:

Provide each group medical insurance policy that Duke Kentucky currently maintains.

RESPONSE:

Duke Energy does not provide insurance to employees through an insurance carrier. See STAFF-DR-01-040(a) through (f) Attachments, which are the self-insured Summary Plan Descriptions for group medical plans.

PERSON RESPONSIBLE: Renee H. Metzler

DUKE ENERGY®

Active Medical Plan

Health Savings Plan 1 option

January 2018

This document replaces any documents previously issued which described your benefits.

Duke Energy Active Medical Plan
General Information

IMPORTANT NOTICE

This General Information booklet for the Duke Energy Active Medical Plan ("Medical Plan") provides information that is applicable to all Medical Plan coverage options. This booklet addresses eligibility for coverage under the Medical Plan, how to enroll, opportunities to make mid-year changes, when coverage ends and how you and your covered dependents may be able to continue coverage if it ends. It also contains information such as who provides coverage, who administers the Medical Plan, who decides claims for benefits, ERISA rights and Duke Energy Corporation's right to amend or terminate the Medical Plan.

The attached Medical Plan booklets and summaries of benefits describe your Medical Plan benefits, applicable deductible, co-pay and co-insurance information, how to submit a claim for Medical Plan benefits and other important information about your Medical Plan.

This General Information booklet, together with the Medical Plan booklets and summaries of benefits, is the Summary Plan Description (SPD) for the Medical Plan as of January 2018 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

TABLE OF CONTENTS

Page

Medical Coverage Availability

Duke Energy Corporation ("Duke Energy") offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (the "Claims Administrators"). The Medical Plan includes medical, surgical, hospitalization, prescription drug, wellness and disease management benefits.

There are various Medical Plan coverage options available, such as high-deductible health plan (HDHP) and preferred provider organization (PPO) options. If you do not have adequate access to network providers, you may qualify for an out-of-area (OOA) option. All of the Medical Plan options are designed to help you pay for health care expenses.

Duke Energy myHR™ Service Center

If you have any questions about the Medical Plan or the information in this General Information booklet, contact the Duke Energy myHR Service Center at 1-888-465-1300. Information also is available through the *Your Benefits Resources*™ (YBR) website at http://resources.hewitt.com/duke-energy.

Eligibility

Eligible Employees

Generally, you are eligible for coverage under the Medical Plan on your first day of active work as an eligible employee (provided you enroll within 31 calendar days of the date you become an eligible employee).

To be an eligible employee, you must be identified in and paid through Duke Energy's payroll system as an employee of Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan (individually or collectively referred to with Duke Energy as the "Company," as appropriate) and you must be classified by your Company as a:

- regular employee; or
- fixed-term employee.

Generally, you are a regular employee if you fill a regular position that is typically longer than 180 days in duration, and you are a fixed-term employee if you are hired for a position for a specifically defined time frame, duration of a project (usually one year or less), until services are no longer needed, or until the work goes away.

You are not eligible to participate in the Medical Plan if you are:

- a non-resident alien with no U.S. source income;
- not on a U.S. payroll of the Company;
- covered by a collective bargaining agreement, unless the collective bargaining agreement in effect expressly provides for participation in the Medical Plan (a copy of your applicable collective bargaining agreement can be obtained from your union steward, union hall, Duke Energy Labor Relations contact or immediate supervisor);

- an individual who has waived eligibility through any means, including an individual whose employment is governed by a written agreement (including an offer letter setting forth terms and conditions of employment) that provides the individual is not eligible for benefits (a general statement in the agreement, offer letter or other communication stating that the individual is not eligible for benefits is construed to mean that the individual is not eligible to participate in the Medical Plan); or
- a temporary employee, a seasonal employee or any other employee who is not a regular employee or fixed-term employee.

In some circumstances, an individual who provides services to the Company under an agreement that identifies the individual as an independent contractor or through a third party (such as a contracting services firm, temporary agency or leasing organization) may be considered a Company "employee" for certain purposes under the law, such as tax withholding. Such an individual is not paid through the Company's payroll system and is not eligible for the Medical Plan.

Eligible Dependents

When you enroll for certain coverage, you may elect to cover your eligible dependents, which may include:

- your eligible spouse
- your eligible domestic partner
- your eligible child(ren)

Spouse Eligibility

Your spouse, eligible for coverage as a dependent, is a person to whom you are legally married under applicable law, which may include "common law marriage" and "same-sex marriage."

Generally, for health coverage of a taxpayer's spouse to be tax-free to the taxpayer, the spouse must be recognized as such under applicable state law and any related federal guidance, which may include "common law marriage" and "same-sex marriage."

By enrolling your spouse in the Medical Plan, you are affirmatively representing that your spouse is eligible for coverage under the Medical Plan. Failure to drop your spouse from coverage constitutes a continuous affirmation of your spouse's eligibility.

You must immediately report any spouse who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your spouse's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible spouse, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your spouse after your spouse ceases to be eligible will be considered a misrepresentation of your spouse's eligibility.

Domestic Partner Eligibility

If you are enrolled in Medical Plan coverage, you can elect coverage for your eligible same- or opposite-sex domestic partner. You and your domestic partner must continuously:

- be each other's sole domestic partner, and intend to remain so indefinitely;
- be at least 18 years of age and mentally competent to enter into a legal contract;
- have lived together in a common household for the immediately preceding 6 consecutive months;
- share financial obligations of, and be jointly responsible for, the common household;
- not be legally married to or legally separated from anyone else, nor in a domestic partnership with anyone else; and
- not be related by blood or marriage to a degree of closeness that would prohibit marriage to one another in your current state of residence.

By enrolling your domestic partner in the Medical Plan, you are affirmatively representing that your domestic partner is eligible for coverage under the Medical Plan. Failure to drop your domestic partner from coverage constitutes a continuous affirmation of your domestic partner's eligibility.

You must immediately report any domestic partner who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your domestic partner's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible domestic partner, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your domestic partner after your domestic partner ceases to be eligible will be considered a misrepresentation of your domestic partner's eligibility.

Child Eligibility

Your child is:

- your biological child, up to age 26; **or**
- your legally adopted child, including a child placed in your home for legal adoption by you as long as the child remains in your home and the adoption procedure has not been terminated, and whether or not the adoption has become final, up to age 26; **or**
- your stepchild, up to age 26; **or**
- your foster child, up to age 26; **or**
- your domestic partner's biological child, legally adopted child (including a child placed in your home for legal adoption by your domestic partner as long as the child remains in your home and the adoption procedure has not been terminated, whether or not the adoption has become final), stepchild or foster child, who is primarily dependent on you for support, whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26; **or**
- any other child for whom you, your spouse or your domestic partner has legal guardianship, full or joint legal custody or managing conservatorship under a valid court decree, who is primarily dependent on you for support, whom you claim as a dependent

for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26.

In addition, your child may be covered at any age if:

- he or she became physically or mentally incapable of self-support while enrolled in a Company-sponsored medical plan and before reaching the applicable limiting age of 26 and continuously remains incapacitated and enrolled in a Company-sponsored medical plan; **or**
- he or she was physically or mentally incapable of self-support on your date of employment with the Company, was enrolled in a Company-sponsored medical plan as of your employment date and continuously remains incapacitated and enrolled in a Company-sponsored medical plan.

By enrolling a dependent child in the Medical Plan, you are affirmatively representing that the child is eligible for coverage under the Medical Plan. Failure to drop your child from coverage constitutes a continuous affirmation of your child's eligibility.

You must immediately report any dependent child who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your dependent child's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible dependent child, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your child after your child ceases to be eligible will be considered a misrepresentation of your child's eligibility.

An eligible child only can be covered by one Company employee or retiree.

Surviving Spouse, Domestic Partner and Child Eligibility

If you die while you and your spouse/domestic partner are covered under the Medical Plan, your surviving spouse/domestic partner may continue Medical Plan coverage by making contribution payment arrangements with the Duke Energy myHR Service Center. This coverage can be continued until the earliest of your spouse's remarriage, your domestic partner's establishment of a new domestic partner relationship, the death of your spouse/domestic partner and the date that your spouse/domestic partner becomes eligible for other coverage (e.g., through an employer's plan or Medicare).

If you are survived by dependent children, their medical coverage may continue for as long as they:

- continue to meet the definition of eligible dependents; and
- make required payments for coverage. Payment arrangements should be coordinated with the Duke Energy myHR Service Center.

This provision applies even if your spouse/domestic partner dies or loses coverage after you.

Your surviving spouse/domestic partner and/or dependent children will be charged for their component of the contribution for coverage. If coverage under the Medical Plan is declined or

ends, your covered dependents may be eligible for continued coverage under COBRA for up to 36 months in certain situations.

Your spouse/domestic partner must immediately report any dependents who should be dropped from survivor coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your dependent's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for ineligible dependents, your spouse/domestic partner should contact the Duke Energy myHR Service Center. Any failure to drop coverage for a dependent after the dependent ceases to be eligible will be considered a misrepresentation of the dependent's eligibility.

See *Termination of Coverage for Non-Payment* for a description of what happens when required payments for coverage are not made.

If you are covered under the Medical Plan and your spouse/domestic partner is an eligible retiree who is covered as your dependent, your spouse/domestic partner may elect retiree coverage under the Duke Energy Retiree Medical Plan or individual coverage through an insurance exchange at the time of your death if your spouse/domestic partner has not reached age 65 at the time of your death, or may be able to elect individual coverage through a Medicare exchange if your spouse/domestic partner is age 65 or older at the time of your death.

Employee and Retiree Couples

No one may be considered as a dependent of more than one employee or more than one retiree.

Verification of Dependent Status

By enrolling your dependent in the Medical Plan, you are affirmatively representing that your dependent is eligible for coverage under the Medical Plan. You will be required to provide evidence of dependent eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order, adoption papers or proof of joint residency within 30 calendar days following the date of enrollment. If you fail to provide proper evidence of dependent eligibility in a timely manner, coverage for your dependent generally will end 45 calendar days following the date of enrollment. See *Claims Determination Procedures* for a description of how to file an eligibility or enrollment claim if your dependent's Medical Plan coverage ends due to a failure to timely provide evidence of dependent eligibility. If your claim or appeal is granted, coverage for your dependent may be reinstated retroactively to the date coverage for your dependent was dropped.

To continue coverage beyond age 26 for a child who is physically or mentally incapable of self-support, you must provide evidence of your child's incapacity to the Medical Plan Claims Administrator. The application can be obtained by contacting the Duke Energy myHR Service Center. You may be required periodically to provide evidence of the child's continuing incapacity.

If a Dependent Becomes Ineligible

If a covered spouse, domestic partner or dependent child becomes ineligible for coverage during the year (for example, if your child reaches age 26), the individual(s) who become(s) ineligible for coverage will be dropped from your coverage.

You must immediately report any dependents who should be dropped from coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. When you report a dependent's loss of eligibility within 31 calendar days of the loss of eligibility:

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage; and

- changes to your contribution amounts will be made as soon as administratively practicable after the date on which you notify the Duke Energy myHR Service Center that your dependent is no longer eligible.

If you do not inform the Duke Energy myHR Service Center of a covered dependent's ineligibility within 31 calendar days of the loss of eligibility:

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage;

- no changes to your coverage level, if applicable, may be made until the next annual enrollment period or, if earlier, the date you experience another work/life event which allows you to change your Medical Plan election (this means that you must continue to pay for the dependent's coverage through the end of the year in which the dependent loses eligibility for coverage even though he or she is no longer covered, unless you experience another work/life event which allows you to change your Medical Plan election);

- the coverage provided while your dependent is ineligible will be considered as part of the individual's COBRA coverage period (this period begins on the first day of the month following the month in which eligibility is lost); and

- COBRA contributions (102% of the total cost) will be required to pay for the coverage received since the end of the month in which eligibility was lost if the individual elects continuation of coverage under COBRA.

To drop coverage for ineligible dependents, contact the Duke Energy myHR Service Center.

The Company reserves the right to seek recovery of any benefits paid under the Medical Plan to your ineligible dependents.

Enrolling in the Medical Plan

When You Are First Eligible

When you are eligible to enroll, you will make your Medical Plan election using an online enrollment tool. You will receive additional information about the online enrollment tool when you become eligible.

If you have questions or need assistance in making your Medical Plan election, contact the Duke Energy myHR Service Center.

When you enroll in the Medical Plan as an eligible employee, based on the dependent(s) that you elect to cover, if any, your coverage level will be one of the following:

- Individual Only
- Individual + Spouse/Domestic Partner
- Individual + Child(ren)
- Individual + Family (Spouse/Domestic Partner and Child(ren))

You must make your election within 31 calendar days of becoming eligible for coverage in order for coverage to begin on the date you become an eligible employee. If you do not make your election within 31 calendar days of becoming eligible, your next opportunity to enroll will be during a subsequent annual enrollment period or within 31 calendar days of a work/life event for which mid-year changes are allowed.

By accessing the enrollment tool or calling the Duke Energy myHR Service Center and making your coverage election when you are first eligible, you are affirmatively representing that all information provided during enrollment including, but not limited to, the eligibility of any dependents for coverage and/or your non-tobacco user status (and that of your spouse/domestic partner, as applicable) is true and correct. If Duke Energy discovers that any information you provide during enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

You also may decline coverage altogether.

During Annual Enrollment

Each fall you will have the opportunity to change your Medical Plan election for the following plan year, including changing your coverage option or electing to drop or add eligible dependents. This process is referred to as "annual enrollment." You will receive information and instructions each fall about annual enrollment.

By accessing the enrollment tool or calling the Duke Energy myHR Service Center and making (or not changing, as applicable) your coverage election during annual enrollment, you are affirmatively representing that all information provided during annual enrollment including, but not limited to, the eligibility of any dependents for coverage, your completion of any wellness program initiatives and/or your non-tobacco user status (and that of your spouse/domestic partner, as applicable) is true and correct. If Duke Energy discovers that any information you provide during annual enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

Other Opportunities to Enroll

Under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you can enroll yourself and your eligible dependents for coverage under the Medical Plan during the year if:

- you or your dependent had other coverage under another health plan or health insurance at the time the Medical Plan was previously offered to you; and
- you did not enroll in the Medical Plan; and
- you or your dependents lose such other coverage and are otherwise eligible for coverage under the Medical Plan.

To enroll for Medical Plan coverage in such a circumstance, the following conditions must be satisfied:

- The other coverage was:
  - Under a federal continuation provision (COBRA) and the continuation period for the other coverage was exhausted. (COBRA coverage is considered exhausted when it ceases for any reason other than either failure of the individuals to pay contributions on a timely basis or for cause (fraudulent or intentional misrepresentation).)
  - Not under COBRA and the other coverage terminated as a result of (1) loss of eligibility (such as loss of eligibility due to legal separation, divorce, death, termination of employment or reduction in the number of hours of employment), or (2) employer contributions toward the other coverage end.

In any case, the other coverage must not have terminated because you failed to pay timely contributions, or for cause (such as filing fraudulent claims).

HIPAA also allows you to enroll yourself, your eligible spouse and/or your newly eligible child if you acquire an eligible dependent through marriage, birth, adoption or placement for adoption.

If you need to enroll for coverage under the Medical Plan as a result of one of these events (such as loss of other coverage, or because you acquire an eligible dependent through marriage, birth, adoption or placement for adoption) you must enroll within 31 calendar days of the event. Otherwise, unless a subsequent work/life event giving rise to a mid-year change occurs (see *Mid-Year Changes*), you must wait until the next annual enrollment.

HIPAA also allows you to enroll yourself and your eligible dependents for coverage under the Medical Plan during the year if:

- you or your eligible dependents lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you or your eligible dependents, as applicable, are no longer eligible; or
- you or your eligible dependents become eligible for premium assistance under a Medical Plan option through a state's premium assistance program under Medicaid or CHIP.

If you need to enroll for coverage under the Medical Plan as a result of one of these two events, you must enroll within 60 calendar days of the event. Otherwise, unless a subsequent work/life event giving rise to a mid-year change occurs (see *Mid-Year Changes),* you must wait until the next annual enrollment.

If You Are Rehired

If your Medical Plan coverage ends due to your termination of employment with the Company or layoff and you are reemployed by the Company as an active employee within 31 calendar days

and within the same plan year, you will be automatically reenrolled in the Medical Plan (in the previous coverage option and at the previous coverage level). If you have experienced a work/life event for which you can make a change in your Medical Plan election (such as marriage, divorce or birth), you can add and/or drop coverage for your eligible dependent(s), as applicable, within 31 calendar days of the date you again become an eligible employee. If you are reemployed more than 31 calendar days after your termination or in a subsequent plan year, you must reenroll as a new employee.

If you retire from the Company as an eligible retiree and are later rehired as an eligible active employee, you will be eligible for coverage as an active employee. When your employment subsequently terminates, you may be able to reelect retiree coverage under the Duke Energy Retiree Medical Plan or individual coverage through an insurance exchange if you are not yet age 65 at that time, or you may be able to elect individual coverage through a Medicare exchange if you are age 65 or older at that time.

Cost of Coverage

You and the Company share in the cost of medical coverage for yourself and your covered dependents. Your contribution amount is based on the Medical Plan coverage option that you elect and the eligible dependent(s) you choose to cover. Information about contribution amounts is available through the YBR website.

Your contributions for medical coverage while an employee are deducted from your pay on a pre-tax basis each pay period. Because your contributions are taken as deductions on a pre-tax basis, they are not subject to federal income, Social Security and most states' income taxes.

Even though you reduce your income for tax purposes through pre-tax contributions for medical coverage, you are not reducing the value of your other Company pay-related benefits, such as life insurance, disability insurance and retirement benefits. These benefits are based on your pay before contributions for medical coverage are deducted.

If you elect coverage for a domestic partner, the portion of your contribution required to cover the domestic partner under the Medical Plan is deducted on a pre-tax basis. On pay advice statements, the value of the coverage associated with the benefits you elected under the Medical Plan for your domestic partner will appear as imputed income and is subject to applicable taxes. Please note that the Company does not provide tax advice, and you should consult with your tax advisor for information about the tax consequences of electing coverage for a domestic partner.

Live Well Incentive Program

Under the Duke Energy *Live Well* Incentive Program (the "*Live Well* Program"), you and your spouse/domestic partner may be eligible to earn rewards that will be applied to reduce your contributions for coverage under the Medical Plan during the following calendar year. For example, if you complete a Biometric Screening under the *Live Well* Program during an applicable year's program cycle, or if your spouse/domestic partner completes a Health Survey under the *Live Well* Program during an applicable year's program cycle, the rewards you and your spouse/domestic partner earn for completing these activities may be applied to reduce your contributions for medical coverage each pay period throughout the following year on a pro-rated basis (i.e., applied evenly to reduce the contribution you make toward the cost of medical coverage each payroll period during the following year).

Employee Eligibility

You are eligible to earn rewards under the *Live Well* Program if you are a U.S.-based active employee who is eligible for the Medical Plan or if you are a U.S.-based employee on an approved paid leave of absence who is eligible for the Medical Plan, whether or not you are enrolled in the Medical Plan. However, you are not eligible to earn rewards under the *Live Well* Program if you are approved for an unpaid leave of absence or long-term disability benefits under a Duke Energy-sponsored long-term disability plan.

Any rewards you earn under the *Live Well* Program will generally be applied to reduce your contributions for coverage under the Medical Plan during the following calendar year. However, if you do not enroll in the Medical Plan for a calendar year, or you are an employee who will be covered under the Medical Plan in a calendar year as a dependent of another Company employee, your *Live Well* Program rewards earned during an applicable year's program cycle will be paid in cash (less applicable taxes) on a prorated basis in your paycheck each pay period during the following calendar year.

There are instances in which you may not receive the *Live Well* Program rewards you have earned, as described below.

- If you are not enrolled in the Medical Plan while you are on an unpaid leave of absence or receiving long-term disability benefits under a Duke Energy-sponsored long-term disability plan, you will not receive any rewards that you earned during the prior year's program cycle that have not been redeemed when your leave of absence or long-term disability benefits commence. You will receive the rewards that you earned during the prior year's program cycle only if you return to active employment during the calendar year following the year in which you earned your rewards, in which case your remaining rewards will be paid to you in cash (less applicable taxes) on a prorated basis in your paycheck during the remaining pay periods in that calendar year.

- If you terminate your employment during a calendar year, you will not receive the rewards that you earned during the prior year's program cycle that have not been redeemed as of your termination date.

- You will not receive the rewards that you earned during the prior year's program cycle that have not been redeemed as of the date you cease to be eligible for the Medical Plan.

Spouse/Domestic Partner Eligibility

Your spouse/domestic partner is eligible to participate in the *Live Well* Program only if you are eligible to participate in the *Live Well* Program as described above, and your spouse/domestic partner is actually enrolled in the Medical Plan. If you are not eligible to participate in the *Live Well* Program, your spouse/domestic partner is not eligible to participate in the *Live Well* Program either, even if your spouse/domestic partner is actually enrolled in the Medical Plan.

If your spouse/domestic partner does not enroll in the Medical Plan for a calendar year, neither you nor your spouse/domestic partner will receive *Live Well* Program rewards your spouse/domestic partner earned during the preceding year's program cycle. This means that your spouse's/domestic partner's *Live Well* Program rewards earned during the preceding year's program cycle will not be used to reduce your contributions for medical coverage throughout the calendar year and will not be paid to you or your spouse/domestic partner in cash.

Live Well Program Activities and Rewards

The activities that you and/or your spouse/domestic partner must complete to receive *Live Well* Program rewards may vary with each program cycle. Review the *Live Well* Program materials sent to you prior to the beginning of each calendar year for additional information on the upcoming program cycle's activities and requirements.

The Medical Plan is committed to helping you achieve your best health. Rewards for participating in the *Live Well* Program are available to all employees who are eligible to participate in the Medical Plan, regardless of Medical Plan enrollment. If you think you might be unable to complete an activity required for you to receive a reward under the *Live Well* Program, you might qualify for an opportunity to earn the same reward by different means. Contact Health and Wellness Portal Support at 1-877-818-5826 and a representative will work with you (and, if you wish, your doctor) to find an activity with the same reward that is right for you in light of your health status.

Non-Tobacco User Discount

A non-tobacco user discount also is available to reduce the cost of coverage under the Medical Plan coverage options. To qualify for the applicable non-tobacco user discount, you (and your spouse/domestic partner) must:

- be tobacco free (including smokeless tobacco and electronic cigarettes);
- have been tobacco-free (including smokeless tobacco and electronic cigarettes) during the 12 months preceding the effective date of your coverage (or during such other period as may be communicated to you in your annual enrollment materials); and
- remain tobacco free (including smokeless tobacco and electronic cigarettes) during the coverage period.

In order to receive the non-tobacco user discount for you and/or your spouse/domestic partner you must complete:

- a non-tobacco user attestation ("Attestation") when you enroll in the Medical Plan using the online enrollment tool or through the Duke Energy myHR Service Center, and
- if you attest to being a tobacco user, the Alternate Procedure Certification described below by the specified deadline.[1]

If you do not complete the Attestation during enrollment, or, if you complete the Attestation and attest to being a tobacco user but you do not complete the Alternate Procedure Certification described below by the applicable deadline, you (and your spouse/domestic partner) will not receive the non-tobacco user discount for Medical Plan coverage. Tobacco user status does not carry over from year to year for Medical Plan coverage.

[1]We will work with you (and/or your spouse/domestic partner) and, if you wish, with your doctor and/or your spouse's/domestic partner's doctor, prior to the Alternate Procedure Certification submission deadline, to find an alternate procedure that provides the same non-tobacco user discount that is right for you (and/or your spouse/domestic partner) in light of your (and/or your spouse's/domestic partner's) health status.

By completing the Attestation in the online enrollment tool or through the Duke Energy myHR Service Center, you are affirmatively representing your (and your spouse's/domestic partner's) tobacco user status and if you (and your spouse/domestic partner) are tobacco-free, your eligibility for the non-tobacco user discount under the Medical Plan. If you complete the Attestation as a non-tobacco user during enrollment and you (or your spouse/domestic partner) become a tobacco user during the period of coverage, you must notify the Duke Energy myHR Service Center within 31 calendar days of the date that you (or your spouse/domestic partner) become a tobacco user. Changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice.

If you misrepresent your tobacco user status (or the tobacco user status of your spouse/domestic partner) in the Attestation, or if you (or your spouse/domestic partner) become a tobacco user after completing the Attestation as a non-tobacco user and you do not notify the Duke Energy myHR Service Center of the change in tobacco user status, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

Non-Tobacco User Discount – Alternate Procedure for Active Employees

The Medical Plan is committed to helping you (and your spouse/domestic partner) achieve your best health. The non-tobacco user discount is available to all covered employees (and their covered spouses/domestic partners). If you (and/or your covered spouse/domestic partner) do not qualify for the non-tobacco user discount because you are not currently tobacco free, have not been tobacco free for the 12 months preceding the effective date of your coverage (or during such other period as may be communicated to you in your annual enrollment materials) or intend to use tobacco during the coverage period, you may still qualify for the discount if you satisfy one of the following requirements.

- If you are enrolling as a newly eligible employee (and/or a newly eligible spouse/domestic partner), you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - enroll in the Quit for Life Tobacco Cessation Program (the "Quit for Life Program") within 31 days of the date you enroll in your benefits, and
    - properly complete and submit a written Alternate Procedure Certification within 31 days of the date you (and/or your spouse/domestic partner) enroll in your benefits certifying that you (and/or your spouse/domestic partner) have enrolled in the Quit for Life Program and that you (and/or your spouse/domestic partner) will complete the Quit for Life Program within seven months of enrolling in the Quit for Life Program[2] – or –

[2] If you (and/or your covered spouse/domestic partner) enrolled in the Quit for Life Program and you properly completed and submitted the Alternate Procedure Certification within 31 days of the date you (and/or your spouse/domestic partner) enrolled in your benefits, but you (and/or your spouse/domestic partner) have not yet reached your seven month completion deadline for the Quit for Life Program by annual enrollment, you may qualify for the non-tobacco user discount if you properly complete and submit a written Alternate Procedure Certification during annual enrollment on or before the communicated deadline stating that you (and/or your spouse/domestic partner) enrolled in the Quit for Life Program on or before the communicated deadline and that you (and/or your spouse/domestic partner) will complete the

- If you are enrolling during annual enrollment, you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - enroll in the Quit for Life Program on or before the communicated deadline, and
    - properly complete and submit an Alternate Procedure Certification on or before the communicated deadline certifying that you (and/or your spouse/domestic partner) enrolled in the Quit for Life Program on or before the communicated deadline and that you (and/or your spouse/domestic partner) will complete the Quit for Life Program on or before the following June 30.

The Alternate Procedure Certification is found on the Duke Energy Portal. You may contact the Duke Energy myHR Service Center to discuss remitting the information required under the alternate procedure. You will not receive the non-tobacco user discount until your Alternate Procedure Certification has been approved, at which time the non-tobacco user discount will be applied on a prospective basis as soon as administratively practicable.

To enroll in the Quit for Life Program, contact Quit for Life at 1-866-784-8454. You (and/or your spouse/domestic partner) will not be required to pay for the cost of the Quit for Life Program. Please note that the Quit for Life Program takes up to six months to complete. You can begin the Quit for Life Program as soon as you enroll. After your (and/or your spouse's/domestic partner's) initial year of claiming the discount in accordance with this procedure, in order to continue the non-tobacco user discount under the alternate procedure in any future year, a new Alternate Procedure Certification will be required.

If You Do Not Successfully Complete the Alternate Procedure

Duke Energy will audit your (and/or your spouse's/domestic partner's) completion of the Alternate Procedure (including completion of the Quit for Life Program). If you (or your spouse/domestic partner) certify that you will complete the Quit for Life Program and you (and/or your spouse/domestic partner) do not complete the Quit for Life Program by the deadline indicated in the alternate procedure, you must notify the Duke Energy myHR Service Center within 31 calendar days of the date that you (or your spouse/domestic partner) fail to meet the deadline. Changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice or, if earlier, the date that the Company learns of such failure.

If You Misrepresent Information in the Alternate Procedure Certification

If you misrepresent any information in your Alternate Procedure Certification, including, but not limited to, your enrollment in the Quit for Life Program, or if you do not complete the Quit for Life Program by the applicable deadline, Duke Energy reserves the right to recover any contribution amounts you should have paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of health and insurance coverage and/or discharge, and to take other appropriate action.

Quit for Life Program by the original completion date of seven months after your initial enrollment in the Quit for Life Program.

Termination of Coverage for Non-Payment

Your coverage will be terminated for non-payment if:

- you do not make the required payment in full for two months; or
- you call the Duke Energy myHR Service Center to indicate the payment is being sent, but it does not arrive by the due date.

If your coverage is terminated for non-payment, you will receive a Confirmation of Coverage statement indicating that your coverage has been cancelled.

Except in cases of termination of COBRA coverage for non-payment, reinstatement after non-payment is possible if you contact the Duke Energy myHR Service Center no later than three months from the date printed on the Confirmation of Coverage statement. However, past due contributions must be paid in full to reinstate coverage. Reinstatement after non-payment will be allowed only one time. If COBRA coverage is terminated for non-payment, reinstatement is not available. Any amounts owed in arrears at the time of a death or coverage change will continue to be billed and must be paid.

When Coverage and Contributions Begin

When you make your Medical Plan election as a newly eligible employee, coverage begins on the date you become eligible (assuming that you make your election within 31 calendar days of becoming eligible). Deductions for your contributions begin as soon as administratively practicable following the date that you make your election.

When you make your coverage elections during annual enrollment, coverage begins on January 1 of the following calendar year. Deductions for your contributions begin the first pay period of the following calendar year.

Mid-Year Changes

Once you have made your Medical Plan election for the year, you may not change it during that year unless you have a work or life event for which a mid-year election change is permitted and the work or life event results in the gain or loss of eligibility for coverage. Specific information about these "work/life" events and allowable mid-year election changes is available through the YBR website located on the Duke Energy Portal or by contacting the Duke Energy myHR Service Center. A "mid-year election change" refers to any change made to your coverage during a calendar year due to a work or life event that results in the gain or loss of eligibility for coverage.

If you experience a work/life event for which mid-year election changes are allowed, you have 31 calendar days from the date of the event (for example, your marriage date) to change your election. Otherwise, unless a subsequent work/life event giving rise to a mid-year election change occurs, you cannot change your Medical Plan election until annual enrollment.

If you are eligible to make changes, the election you make must be consistent with and on account of the work/life event.

Below is a list of some work/life events for which mid-year election changes are allowed:

- Your legal marital status changes
  - you get married
  - you get divorced or have your marriage annulled
  - you get legally separated and lose coverage under your spouse's employer plan
  - your spouse dies
- Your domestic partner status changes
  - your domestic partner becomes eligible for coverage
  - your domestic partner relationship ends
  - your domestic partner dies
- The number of your eligible children changes
  - you have, or adopt, a child
  - you become the legal guardian of a child
  - your child gains or loses eligibility for coverage under the Medical Plan (for example, your dependent child reaches age 26)
  - a Qualified Medical Child Support Order (QMCSO) is received[3]
  - your child dies
- Your dependent's benefits coverage changes because:
  - he or she gains or loses coverage due to a change in eligibility as a result of a change in employment status or work schedule
  - his or her period of coverage and annual enrollment window is different from yours
- Your or your dependent's COBRA coverage from another employer expires
- You enroll in a qualified health plan through a federal or state Marketplace during the Marketplace's annual enrollment period or during a special enrollment period available in the Marketplace
- You or your dependent becomes entitled to or loses Medicare or Medicaid[4]
- You or your dependent loses or gains coverage under a group health plan
- There is a significant increase or decrease in the cost of coverage under the employer plan in which your dependent participates
- You die

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[3] If a Qualified Medical Child Support Order is issued requiring medical coverage for your child, you may change your medical coverage election to provide coverage for your child. You also may make an election change to cancel medical coverage for the child if the order requires the child's other parent to provide coverage.

[4] Entitlement to Medicare or Medicaid. If you, your spouse or any dependent child is enrolled in the Medical Plan and subsequently become entitled to coverage in Part A or Part B of Medicare or in Medicaid, you may make an election to cancel Medical Plan coverage for that individual.

When Your Dependent Is No Longer Eligible

If a covered dependent ceases to be eligible for benefits, your dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage. If you notify the Duke Energy myHR Service Center within 31 calendar days of the loss of eligibility, changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice. See *If a Dependent Becomes Ineligible* for information about the consequences of failing to notify the Duke Energy myHR Service Center within 31 calendar days of a loss of eligibility.

When You Enroll a Dependent Mid-Year

If your change is to add a dependent to your Medical Plan coverage, and your dependent's eligibility for Medical Plan coverage has not previously been verified, you will be required to provide evidence of dependent eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order, adoption papers or proof of joint residency within 30 calendar days following the date of enrollment. If you fail to provide proper evidence of dependent eligibility in a timely manner, coverage for your dependent generally will end 45 calendar days following the date of enrollment. See *Claims Determination Procedures* for a description of how to file an eligibility or enrollment claim if your dependent's Medical Plan coverage ends due to a failure to timely provide evidence of dependent eligibility. If your claim or appeal is granted, coverage for your dependent may be reinstated retroactively to the date coverage for your dependent was dropped.

When Mid-Year Coverage and Contribution Changes Are Effective

This section outlines the timing of coverage and contribution changes when you (i) elect to start or increase coverage due to a work/life event, (ii) elect to decrease or terminate coverage due to a work/life event or (iii) stop or decrease coverage due to a covered individual becoming ineligible for coverage (e.g., divorce or child reaches age 26).

- **Start or Increase Coverage**. If you elect to start or increase your coverage due to a work/life event, your coverage changes on the day the work/life event occurred. In order for the change to take effect on the day the work/life event occurred, you must notify the Duke Energy myHR Service Center within 31 calendar days of the work/life event. Changes to your contribution amounts are effective as soon as administratively practicable after you submit your election changes.

- **Elective Decrease or Termination of Coverage**. If you elect to decrease or terminate coverage due to a work/life event, your coverage changes on the first day of the month after you submit your election changes. You must notify the Duke Energy myHR Service Center within 31 calendar days of the work/life event in order for the change to become effective on the first day of the month after you submit your election changes. Changes to your contribution amounts are effective as soon as administratively practicable after you submit your election changes.

- **Decrease or Termination of Coverage Due to Loss of Eligibility**. Coverage for individuals who are no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage. Changes to your contribution amounts generally are effective as soon as administratively practicable after you submit your

election changes provided that you notify the Duke Energy myHR Service Center within 31 days of the loss of eligibility. See *If a Dependent Becomes Ineligible* above for the consequences of failing to notify the Duke Energy myHR Service Center of a covered individual's ineligibility within 31 calendar days of the loss of eligibility. Note that in the event of your death, coverage for you and your dependents ends on the date of your death. See *Surviving Spouse, Domestic Partner and Child Eligibility* above for information about coverage available to your spouse/domestic partner and/or child if you die while they are covered under the Medical Plan.

Situations Impacting Your Eligibility for Coverage

If You Are on an Authorized Leave of Absence

While you are on an authorized leave of absence, you may be eligible to continue your coverage under the Medical Plan. Contact the Duke Energy myHR Service Center for additional information regarding your ability to continue coverage under the Medical Plan during an authorized leave of absence. If your authorized leave of absence is unpaid such that you begin to be billed directly for the monthly contribution for your medical coverage, see *Termination of Coverage for Non-Payment* for a description of what happens when required payments for coverage are not made.

If You Become Disabled

If you begin receiving disability benefits under the Duke Energy Short Term Disability Plan or the Duke Energy Long Term Disability Plan, you may be eligible for continued coverage under the Medical Plan. Contact the Duke Energy myHR Service Center for additional information regarding your ability to continue coverage under the Medical Plan if you begin receiving disability benefits. If you begin to be billed directly for the monthly contribution for your medical coverage, see *Termination of Coverage for Non-Payment* for a description of what happens when required payments for coverage are not made.

When You Reach Age 65

If you continue to work past age 65, Medical Plan coverage for you and your covered dependents will continue as long as you remain an eligible employee, your covered dependents remain eligible dependents and you pay any required contributions. If you continue to work past age 65, your Medical Plan coverage will be primary to Medicare for you and any covered dependents over age 65, except in certain situations related to an end stage renal disease diagnosis.

If You Become Entitled to Medicare

If you are "not actively at work" and you become entitled to Medicare, you can elect to continue your coverage under the Medical Plan or enroll in individual coverage through a Medicare exchange. If you wish to continue your enrollment in Duke Energy-sponsored coverage, you will be required to enroll in a Medical Plan option that coordinates with Medicare Part B (note that there is no coordination of benefits between the Medical Plan's prescription drug coverage and Medicare Part D). For these purposes, you are considered to be "not actively at work" if you are not actively working as an employee or you have been receiving long-term disability benefits for six months or longer. Contact the Duke Energy myHR Service Center for additional information regarding the options available to you when you become entitled to Medicare.

If you elect to terminate your coverage under the Medical Plan when you become entitled to Medicare, any of your eligible dependents who are covered under the Medical Plan and are not eligible for Medicare may continue coverage under the Medical Plan until reaching age 65.

If you are "not actively at work" because you have been receiving long-term disability benefits for six months or longer and you and/or a covered dependent enroll in a Medicare prescription drug plan for a calendar year, you and/or your covered dependent will not be eligible for coverage under the Medical Plan for that calendar year. Therefore, Medical Plan coverage ends for a calendar year for individuals who enroll in a Medicare prescription drug plan mid-year. Such individuals may be able to enroll for Medical Plan coverage at the next annual enrollment if Medicare prescription drug coverage is dropped for the following calendar year.

Termination of Coverage

When Coverage Ends

Your coverage under the Medical Plan will cease on the earliest of the following dates:

- the last day of the month in which your employment ends, unless you elect to continue coverage under COBRA;
- the last day of the month in which you cease to be an eligible employee or dependent or otherwise cease to be eligible for coverage under the Medical Plan;
- the last day of the month in which a work stoppage begins;
- the end of the period for which your last required contribution was made;
- the date of your death; or
- the date the Medical Plan is discontinued.

Your dependent's coverage will end when your coverage ends, at the end of the period for which your last required contribution was made, on the last day of the month in which you elect not to cover the dependent, or on the last day of the month in which the dependent loses eligibility, unless he or she continues his or her coverage under COBRA or through survivor coverage, as applicable. Medical Plan coverage actually will terminate, but it will be reinstated retroactive to the coverage termination date if the COBRA enrollment is properly received and processed. COBRA enrollment forms must be completed and received within 60 days of the event or notification, whichever is later.

If You Become Divorced or Your Domestic Partner Relationship Ends

If you cover a spouse/domestic partner under the Medical Plan and you become divorced or your domestic partner relationship ends, you must drop coverage for your former spouse/domestic partner within 31 calendar days of the divorce or the date on which your domestic partner relationship ends. Your former spouse/domestic partner will then be notified that he or she may continue coverage through COBRA by contacting the COBRA administrator within 60 days of the qualifying event.

See *If a Dependent Becomes Ineligible* for a description of what happens when you either do or do not report your divorce or the end of your domestic partner relationship within 31 calendar days.

To drop coverage for your former spouse/domestic partner, contact the Duke Energy myHR Service Center.

If You Leave the Company

If your employment with the Company terminates, your coverage under the Medical Plan will end on the last day of the month in which your employment terminates, unless you elect to continue coverage under COBRA.

See *If You Are Rehired* for a description of what happens if you are reemployed by the Company after your termination of employment.

If You Retire

If you are an eligible retiree, you may elect retiree coverage under the Duke Energy Retiree Medical Plan or individual coverage through an insurance exchange if you have not reached age 65 when you retire, or individual coverage through a Medicare exchange if you are age 65 or older when you retire. Additional information about your coverage options will be provided to you when you retire.

COBRA Continuation Coverage

Under COBRA (Consolidated Omnibus Budget Reconciliation Act), you, your spouse and eligible dependent children may elect to continue Medical Plan coverage if certain qualifying events occur. Although domestic partners are not entitled to continuation coverage under COBRA, the Company will apply the same rules to a domestic partner as to a spouse.

There also may be other coverage options available to you and your family if you experience a qualifying event. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace.

Continued Coverage for You

You may continue coverage for yourself and your covered eligible dependents under the Medical Plan for up to 18 months if you lose coverage under the Medical Plan due to:

- termination of your employment (for reasons other than gross misconduct); or
- a reduction of your work hours.

Continued Coverage for Your Dependents

Your covered dependents may continue their coverage under the Medical Plan for up to 36 months if they lose coverage as a result of your:

- death;
- divorce;
- termination of domestic partner status; or
- dependent child ceasing to be a dependent as defined by the Medical Plan.

Newborn and Adopted Children

If you give birth or adopt a child while you are on COBRA continuation coverage, you may enroll your new child for COBRA coverage within 31 calendar days following the date of the birth or adoption. Your newborn or adopted child will be a "qualified beneficiary." This means that your child will have independent election rights and multiple qualifying event rights. (Refer to *Multiple Qualifying Events*.)

In Case of Disability

You and your covered dependents may be eligible for up to 29 months of continued coverage if you or your dependents receive a determination from the Social Security Administration stating that you or your dependents were disabled at the time you elected COBRA coverage or at any time during the first 60 days of COBRA coverage, provided the disability lasts at least until the end of the 18-month period of continuation coverage.

You must notify the Duke Energy myHR Service Center of any Social Security Administration disability determination in writing within the initial 18-month coverage period and within 60 days of the determination. Your verbal notice is not binding until confirmed in writing and the Duke Energy myHR Service Center receives a copy of the Social Security disability determination. You also must notify the Duke Energy myHR Service Center within 30 days of the date you are determined by the Social Security Administration to no longer be disabled.

If You Become Covered by Medicare

If you become entitled to Medicare while you are an active employee and you later experience a qualifying event (e.g., a termination of employment), you and your dependents may be eligible for continued coverage when the qualifying event occurs. If COBRA is elected, coverage for your covered dependents will extend 36 months from the date you first became covered by Medicare or the maximum coverage period for the qualifying event (18 months in the case of termination of employment or reduction in hours) whichever is later.

For example, suppose you are actively employed on January 1, 2018, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2019, your eligible dependents would be eligible for continued coverage until the later of:

- 36 months following the date you become covered for Medicare – January 1, 2021; or

- 18 months following your termination of employment – July 1, 2020

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2021 if COBRA continuation coverage is elected.

Multiple Qualifying Events

If your dependents experience more than one qualifying event while COBRA coverage is active, they may be eligible for an additional period of continued coverage not to exceed 36 months from the date of the first qualifying event.

For example, if you terminate employment, you and your dependents may be eligible for 18 months of continued coverage. During this 18-month period, if your dependent child ceases to be a dependent under the Medical Plan (a second qualifying event), your child may be eligible for an additional period of continued coverage. This period would not exceed a total of 36 months from the date of the loss of your coverage due to your termination (the first qualifying event).

Procedures to Obtain Continued Coverage

Both you and the Company have responsibilities if qualifying events occur that make you or your covered dependents eligible for continued coverage.

You or your covered dependents must notify the Duke Energy myHR Service Center within 60 days when one of these qualifying events occurs:

- you become divorced;
- your domestic partner relationship ends;
- your dependent child is no longer considered an eligible dependent as defined by the Medical Plan; or
- you or an eligible dependent is determined to be disabled by the Social Security Administration.

If these procedures are not followed, or if notice is not provided to the Duke Energy myHR Service Center during the 60-day notice period, then your covered dependents will lose their rights to elect COBRA coverage.

For other qualifying events, such as your death, termination of employment or reduction in work hours, it is the Company's responsibility to notify the COBRA administrator.

Election Period

The Company's COBRA administrator will notify you or your covered dependents of your right to elect continued coverage. Each qualified beneficiary has independent election rights and has 60 days to elect coverage, beginning on the later of:

- the date coverage terminates by reason of the qualifying event, or
- the date notification of the right to elect continued coverage is mailed to you and your covered dependents.

Type of Coverage

If you choose continued coverage, you will initially have the same medical coverage you had on the day before your qualifying event. During your COBRA continuation period, any changes to the medical coverage of similarly situated active employees also will apply to your medical coverage as a COBRA qualified beneficiary. In addition, if your COBRA continuation period extends into a future plan year, you will be able to change your Medical Plan COBRA election for the following plan year during annual enrollment to the same extent that similarly situated active employees are able to change their Medical Plan elections for the following plan year during annual enrollment.

Cost

You and your covered dependents will be required to pay 102% of the full group cost for your continued coverage. The 2% is intended to cover administrative fees. The contributions are paid on an after-tax basis.

You will be asked to pay for coverage in monthly installments. Your first payment will be retroactive to the date of your qualifying event and will be due no later than 45 days after the date you elected continued coverage. Coverage will be effective once the initial premium is paid. Once payment is received, notification of coverage will be passed on to the applicable Claims Administrator. You may refile claims that may have been denied between your benefits termination and your election to continue coverage. You will be required to make monthly payments thereafter, with a 30-day grace period. If the cost or benefits change in the future for active employees, the changes also will affect continued coverage under COBRA. You will be notified of any changes in the cost or benefits associated with your coverage.

Termination of Continued Coverage

COBRA coverage automatically ends if any of the following occurs:

- the COBRA participant fails to make the required contribution on time;
- the Company terminates the Medical Plan for all employees; or
- the COBRA participant becomes covered under another group medical plan (as an employee or otherwise) after the election of COBRA coverage.

Conversion Privilege

The Medical Plan has no conversion privilege. This means that you are not able to convert your coverage under the Medical Plan to an individual policy upon your termination from the Company or when coverage ends.

Qualified Medical Child Support Orders (QMCSOs)

If the Company receives notification that, as a result of a QMCSO, you are required to provide Medical Plan coverage for a dependent child, the Company will:

- notify you (and any other person named in the order) of receipt of the order; and

- within a reasonable period of time (up to 30 days), determine if the child is eligible for coverage under the Medical Plan and notify you in writing of the decision.

As appropriate to the court order, the child will be enrolled for medical coverage, unless there are legal proceedings that dispute the determination. If the court order is disputed, claims processing will be delayed until the dispute is resolved.

If the child's covered expenses are paid by a custodial parent or legal guardian who is not a participant in the Medical Plan, reimbursement of these expenses will be made directly to the custodial parent or legal guardian if required by the order. Custodial parents and legal guardians also may sign claim forms and assign benefits to providers. The Claims Administrator will send notification of payment of providers to the custodial parent.

If you do not comply with the procedures required by the order, the Company may change your coverage status to that required by the court order and deduct the appropriate contributions from your pay at the direction of the court.

Your Role

As a participant in the Medical Plan, please follow the guidelines below.

- File accurate claims. If someone else (other than the provider) files a claim on your behalf, you must review the form before you sign it.
- Review the explanation of benefits when it is returned to you. Make sure that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered.
- Never allow another person to seek medical treatment under your identity.
- Provide complete and accurate information on claim forms and any other forms; answer all questions to the best of your knowledge.

You must notify the applicable Claims Administrator if a provider:

- bills you for services or treatment that you have never received;
- asks you to sign a blank claim form; or
- asks you to undergo tests that you feel are not needed.

Any covered person who knowingly intends to defraud the Medical Plan will be considered guilty of fraud. If you are concerned about any of the charges that appear on a bill or explanation of benefits form or if you know of or suspect any illegal activity, call the applicable Claims Administrator at the toll-free number on your I.D. card. All calls are strictly confidential.

Other Important Information

Plan Sponsor

Duke Energy Corporation is the sole sponsor of the Medical Plan. The Company address, telephone number and employer identification number (EIN) are:

Duke Energy Corporation
550 South Tryon Street
Charlotte, NC 28202
980-373-8649
EIN: 20-2777218

Identification Numbers

If you need to correspond with the federal government about the Medical Plan, you should include in the correspondence the Duke Energy Corporation EIN and the plan number assigned to the Medical Plan. The Medical Plan is a component plan under the Duke Energy Active Health & Welfare Benefit (Financed) Plans, plan number 502.

Funding

Benefits under the Medical Plan generally are provided from funds held by trustees. All Medical Plan claims are paid from the Duke Energy Corporation Welfare Benefits Trust VEBA I with Bank of New York Mellon as trustee. The address for Bank of New York Mellon is:

Bank of New York Mellon
BNY Mellon Center
500 Grant Street
Pittsburgh, PA 15258

The Company also may provide benefits under the Medical Plan from its general assets.

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy Benefits Committee (the "Benefits Committee"). The Benefits Committee has responsibility and authority to control and manage the operation and administration of the Medical Plan, except to the extent delegated or assigned to others.

The Benefits Committee may assign or delegate any of its authority or duties to others. The Benefits Committee has appointed Duke Energy Human Resources to serve as the Initial Claim Administrator and the Duke Energy Claims Committee (the "Claims Committee") to serve as Denied Claim Reviewer for claims as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or any coverage option under the Medical Plan. The Benefits Committee, the Claims Committee and Duke Energy Human Resources may be contacted as follows:

Benefits Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

Claims Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

Duke Energy Human Resources
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

The Benefits Committee has appointed the Claims Administrators to serve as Initial Claim Administrators and Denied Claim Reviewers for claims for benefits under the Medical Plan. The Claims Administrators may be contacted at the addresses listed in the Medical Plan booklets. You also can obtain additional information by contacting the Duke Energy myHR Service Center.

The Benefits Committee, the Claims Committee, Duke Energy Human Resources and the Claims Administrators, and/or any delegate thereof, each within its area of authority and responsibility, have power and discretion to construe and interpret the Medical Plan and to make factual determinations.

Investment Committee

The named fiduciary for the maintenance and investment of the plan assets that are held in the Duke Energy Corporation Welfare Benefits Trust VEBA I is the Duke Energy Investment Committee. The Board of Directors of Duke Energy Corporation appointed the Chairman of the Investment Committee, who in turn appoints the other members of the Investment Committee. Any successor Chairman of the Investment Committee is appointed by the Finance and Risk Management Committee of the Board of Directors of Duke Energy Corporation.

The Investment Committee may be contacted through the following address:

Investment Committee
Director, Long Term Investments
Duke Energy Corporation
550 South Tryon Street, DEC40A
Charlotte, NC 28202

Plan Year

The plan year for the Medical Plan is January 1 through December 31.

Service of Legal Process

The person designated for service of legal process upon the Medical Plan is:

Corporate Secretary
Duke Energy Corporation
550 South Tryon Street

Charlotte, North Carolina 28202

Legal process also may be served upon the Medical Plan's trustee, if applicable, or upon the Benefits Committee as Plan Administrator.

Affiliated Employers of Duke Energy That Have Adopted the Medical Plan

Contact the Duke Energy myHR Service Center for information regarding affiliated employers of Duke Energy that have adopted the Medical Plan.

Claim Determination Procedures

There are two different types of claims that may be made under the Medical Plan...Claims for Medical Plan Benefits and Eligibility or Enrollment Claims.

A Claim for Medical Plan Benefits is a claim for Medical Plan benefits made in accordance with the Medical Plan's procedures for filing benefit claims.

An Eligibility or Enrollment Claim is a claim as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or applicable Medical Plan option made in accordance with the Medical Plan's procedures for filing eligibility or enrollment claims. An Eligibility or Enrollment Claim does not include (i) requests to change your Medical Plan coverage level and/or coverage option due to your failure to take action during the applicable enrollment period, (ii) requests to change your Medical Plan coverage level and/or coverage option based solely on a change in your preferred coverage level and/or coverage option, (iii) disputes regarding the cost of your Medical Plan coverage and/or requests to change your Medical Plan coverage level and/or coverage option due to disputes regarding the cost of your Medical Plan coverage, (iv) requests for reinstatement of Medical Plan coverage if your coverage is terminated for non-payment and you have already exhausted your one-time reinstatement opportunity, (v) requests to change your tobacco user status, which includes requests to complete the Alternate Procedure Certification after the communicated deadline or (vi) requests for the Company to record/count wellness activities completed after the communicated deadline.

Claims for Medical Plan Benefits

The Claims Administrators for your Medical Plan options have the authority to decide initial Claims for Medical Plan Benefits, as the Initial Claim Administrators, and denied Claims for Medical Plan Benefits on review, as the Denied Claim Reviewers. The Company has no discretionary authority with respect to Claims for Medical Plan Benefits.

Claims submission procedures for your Medical Plan benefits are described in the Medical Plan booklets for the Medical Plan options in which you participate. You also can obtain additional information by calling the Duke Energy myHR Service Center. To file a valid Claim for Medical Plan Benefits, you (or your authorized representative) must follow the claim submission procedures for the Medical Plan as described in the Medical Plan booklets applicable to the Medical Plan options in which you participate and any updating materials.

Eligibility or Enrollment Claims

The Benefits Committee has appointed Duke Energy Human Resources to decide Eligibility or Enrollment Claims as the Initial Claim Administrator. Duke Energy Human Resources has delegated its authority to decide Eligibility or Enrollment Claims to Alight Solutions Claims and Appeals Management.

The Benefits Committee has appointed the Claims Committee to perform the fair and impartial review of denied Eligibility or Enrollment Claims on appeal as the Denied Claim Reviewer. The Company has no discretionary authority with respect to the Claims Committee's final determinations regarding Eligibility or Enrollment Claims on appeal.

To file a valid Eligibility or Enrollment Claim, you (or your authorized representative) must follow the claim submission procedures for the Medical Plan as described in this General Information booklet and any updating materials.

Initial Claim

If you have an Eligibility or Enrollment Claim, you (or your authorized representative) must submit a claim initiation form. This form can be obtained by calling the Duke Energy myHR Service Center.

The claim form must be submitted in writing to the address on the form and include:

- a statement that the claim is a "Claim for Eligibility/Enrollment" and identification of the Medical Plan;
- your name, Social Security number, mailing address and daytime telephone number;
- a complete description of the claim, including the eligibility/enrollment issue presented;
- dependent information, if applicable; and
- any additional information you want considered.

A "Claim for Eligibility/Enrollment" must be received by Claims and Appeals Management within 12 months after the date on which you are claiming eligibility/enrollment should have occurred. If your claim is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Claims and Appeals Management will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Claims and Appeals Management's control, it will notify you or your representative within 30 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice also will specify what information is needed. The determination period will be suspended on the date Claims and Appeals Management sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice. You will have at least 45 days to respond to the request for information.

Adverse Determination

In the event of an adverse eligibility or enrollment determination, in whole or in part, you (or your authorized representative) will be notified of the adverse determination in writing.

An adverse determination notification for an Eligibility or Enrollment Claim will contain:

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why such information or material is needed;
- an explanation of the claims review process and the time limits applicable to such process, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review and any time limits for filing such a civil action;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request;
- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances; and
- only to the extent required under applicable federal regulations:
    - information sufficient to identify the claim involved;
    - notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
    - a description of the Medical Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and
    - contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

In addition, any such denial notification will be provided in a culturally and linguistically appropriate manner to the extent required by the Patient Protection and Affordable Care Act and any applicable implementing regulations or other federal agency guidance issued thereunder.

Appeal of Adverse Determination

If you disagree with an adverse eligibility or enrollment determination, you (or your authorized representative) can request a review of the initial determination by submitting a written request to the Claims Committee within 180 calendar days after receipt of the adverse determination. If

your appeal is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

A request to the Claims Committee must be submitted in writing to:

Claims Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202

You may request to examine and receive copies of all documents, records and other information relevant to the claim. The Claims Committee will review the appeal without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person that was involved in making the initial decision regarding the claim, or a subordinate to that person. In addition, if the claim was based in whole or in part on a medical judgment, the Claims Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This person will not be a person (or a subordinate of a person) consulted by Claims and Appeals Management in deciding the initial claim. When reviewing an adverse determination that has been appealed, any new information that you provide that was not available or utilized when the initial determination was made will be considered.

You will be allowed to review the claim file and to provide evidence and testimony as part of the internal claims and appeals process. The Claims Committee will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Medical Plan (or at the direction of the Medical Plan) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, if the denial of your appeal is based on a new or additional rationale, the Claims Committee will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. You will be notified regarding the decision on your appeal within 60 days after receipt of the appeal.

The determination of your appeal will be in writing and, if adverse, will contain:

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- a statement about your right to bring a civil action under Section 502(a) of ERISA and any time limits for filing such a civil action;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request;

- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances;
- the following statement: 'You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency'; and
- only to the extent required under applicable federal regulations:
    - information sufficient to identify the claim involved;
    - notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
    - a description of the Medical Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and
    - contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

In addition, any such denial notification will be provided in a culturally and linguistically appropriate manner to the extent required by the Patient Protection and Affordable Care Act and any applicable implementing regulations or other federal agency guidance issued thereunder. Also, upon request, the Claims Committee will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

For additional information on filing an Eligibility or Enrollment Claim or filing an appeal of an adverse determination, you should contact the Claims Committee.

Voluntary External Review Program

Once you have exhausted the internal claims and appeals process, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. External review is available only after internal appeals are exhausted and only for certain types of adverse benefit determinations, as defined by federal regulations.

If your claim is eligible for external review under applicable federal regulations and you wish to file a request for external review, you must submit your request within four months of the date of your receipt of the Claims Committee's final internal adverse determination on your appeal. If your request for external review is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it. Contact the Claims Committee for more information on how to file a request for external review of your appeal.

The Claims Committee will determine if your appeal is eligible for the voluntary external review program and will provide you with a written notice of its determination. If your request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the

request complete, and, in order to pursue an external review, you must provide the required information within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later. If you fail to provide the required information by the applicable deadline, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

If your claim is eligible for external review, the Claims Committee will assign your claim to an IRO. The IRO will notify you of the acceptance of your claim for external review, and this notice will include a statement that you may submit to the IRO in writing within 10 business days following receipt of the notice any additional information the IRO should consider in conducting the external review.

The IRO will review all of the information and documents it receives in a timely manner as outlined in federal regulations and other applicable guidance. You will receive written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to you or the Medical Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

The external review program is completely voluntary, so you only have to exhaust your internal claim and appeal administrative review rights under the Medical Plan in order to bring a civil action against the Medical Plan. Contact the Claims Committee for more information about the Medical Plan's external review procedures.

Legal Action

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the internal claim and appeal procedure. You may not initiate a legal action against the Claims Administrators, the Medical Plan, the Company, or the Plan Administrator until you have completed the internal appeal processes. No legal action may be brought more than one year following a final decision on the claim under the appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority

Authority to decide initial claims (including claims for Medical Plan benefits) under the Medical Plan and denied claims on review (including denied claims for Medical Plan benefits on review) under the Medical Plan includes the full power and discretion to interpret Medical Plan provisions and to make factual determinations, with the Initial Claim Administrators' and the Denied Claim Reviewers' decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to the particular entity identified as having the authority to decide the initial claim, or to decide the denied claim on review, as applicable.

Right to Change or Terminate the Medical Plan

Duke Energy Corporation reserves the right to amend or terminate the Medical Plan in any respect and at any time. For example, the Medical Plan may be discontinued in part or in its entirety, or what the Medical Plan or Medical Plan option covers or what benefits it provides may be changed. Cost sharing between the Company and covered individuals also is subject to change, which may include initiating or increasing contributions required of employees, retirees, other former employees and their dependents.

The amendment or termination of the Medical Plan may affect the benefits or benefit coverage not only of active employees (and their dependents), but also of former active employees who retired (and their dependents), became disabled, died or whose Company employment has otherwise terminated (and their dependents), and also of any covered person who began receiving benefit coverage or payments prior to the amendment or termination. If such a termination or amendment occurs, affected participants will be notified. The right to amend or terminate the Medical Plan may be exercised by Duke Energy Corporation, or its authorized delegates, and any amendment shall be in writing.

In the event of a complete termination of the Medical Plan, eligible claims for Medical Plan benefits will be paid by the Duke Energy Corporation Welfare Benefits Trust VEBA I to the extent that funds are available.

Statement of Rights

As a participant in the Medical Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Medical Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Medical Plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Medical Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Medical Plan, including collective bargaining agreements, and a copy of the latest

annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- receive a summary of the Medical Plan's annual financial report. The Plan Administrator is required by law to furnish each participant in the Medical Plan with a copy of this summary financial report.
- obtain a copy of the Medical Plan's procedures for determining a Qualified Medical Child Support Order (QMCSO).

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse[5] or dependents if there is a loss of coverage under the Medical Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this General Information Booklet and the other documents governing the Medical Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Medical Plan documents or the latest annual report from the Medical Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court once you have exhausted the Medical Plan's internal claims procedures.

In addition, if you disagree with the Medical Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Medical Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If

[5] Additionally, the Company extends continuation of coverage under COBRA to covered domestic partners if they lose eligibility for coverage in certain situations.

you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

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

Keep Us Informed

It is your responsibility to make sure that your benefits records are correct and that the personal information needed to administer your benefits is current. Promptly review any confirmation and other benefit statements carefully, and immediately advise the Duke Energy myHR Service Center if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child is no longer an eligible dependent, contact the Duke Energy myHR Service Center as soon as possible.

A Final Note

Although this General Information Booklet and the other documents that comprise the SPD describe the principal features of the Medical Plan that are generally applicable, the SPD is only a summary. The complete provisions of the Medical Plan are set forth in the plan documents, which are available upon request from Duke Energy Human Resources. An SPD is an overview and is written to be read in its entirety. Descriptions of Medical Plan features should not be taken out of context. Inquiries about specific situations should be directed in writing to Duke Energy Human Resources. Changes to the Medical Plan, pending revision of the SPD, will be communicated in benefit newsletters, letters, Duke Energy Portal announcements and/or enrollment materials. In the event of a conflict between this SPD or any other communication regarding the Medical Plan and the plan documents themselves, the plan documents control. Remember, the Medical Plan may not be amended by oral or written communications.

The Medical Plan, this SPD and your Medical Plan participation are not employment contracts, and do not give any employee the right to continue to be employed by the Company. Employees may resign and are subject to discipline, discharge or layoff as if the SPD had never been published and the Medical Plan had never gone into effect.

The Medical Plan complies with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 888.465.1300. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888.465.1300. 注意：如果您說中文 (Chinese), 我們免費為您提供語言協助服務。請致電：888.465.1300.

Benefit Booklet

Duke Energy Active Medical Plan
Health Savings Plan 1 Option

Effective: January 1, 2018
Group Number: 729784

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/ Substance-Related and Addictive Disorders Administrator: (877) 214-2930.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740809, Atlanta, GA 30374-0800.
- Online assistance: **www.myuhc.com**.

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy Active Medical Plan's Health Savings Plan 1 Option. It includes summaries of:

- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions and Limitations;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Duke Energy is solely responsible for paying Benefits described in this Benefit Booklet.

IMPORTANT
The healthcare service, supply or pharmaceutical product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 12, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Please read this Benefit Booklet thoroughly to learn how the Duke Energy Active Medical Plan's Health Savings Plan 1 Option works. If you have questions call the number on the back of your ID card.

How To Use This Benefit Booklet

- Read the entire Benefit Booklet (including the benefit booklet describing the prescription drug benefit), as well as the General Information Booklet and share them with your family. Together, the General Information Booklet and the Benefit Booklets comprise the Summary Plan Description (SPD) for the Plan's Health Savings Plan 1 Option. Keep these documents in a safe place for future reference.
- Many of the sections of this Benefit Booklet are related to other sections. You may not have all the information you need by reading just one section.
- You can find or request printed copies of your SPD at **http://resources.hewitt.com/duke-energy** or by contacting the Duke Energy myHR™ Service Center at (888) 465-1300.
- Capitalized words in the Benefit Booklet have special meanings and are defined in Section 12, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 12, *Glossary*.
- Duke Energy and its affiliated companies which are participating in the Plan are also referred to as the Company.

SECTION 2 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits;
- Eligible Expenses;
- Annual Deductible;
- Coinsurance; and
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Designated Network Benefits, Network Benefits or Non-Network Benefits.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 4, *Plan Highlights*. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer

to the definition of Shared Savings Program in Section 12, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of the Company or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling

UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The Network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider, or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician

for you. In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

The Plan Administrator has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits. For Designated Network Benefits and Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare determines the Plan will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the Benefit Booklet.

For Designated Network Benefits and Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:

    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in

that geographic area.

- For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a master's level counselor.

- When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.

- When a rate is not published by CMS for the service, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits (other than Benefits for Network preventive care services). The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to almost all Covered Health Services under the Plan, including Covered Health Services provided through the prescription drug program for Network Benefits only. The only Covered Health Services under the Plan to which the Annual Deductible does not apply are Network preventive care services and certain preventive medications and vaccines which are covered at 100% by the Plan even before you meet your Annual Deductible.

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

If more than one person in a family is covered under the Plan's Health Savings Plan 1 Option, the individual coverage Deductible stated in Section 4, *Plan Highlights* does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits (other than Benefits for Network preventive care services and certain preventive medications and vaccines) until the family Deductible is satisfied.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the applicable annual maximum, the Plan pays 100% of additional Eligible Expenses you incur for Covered Health Services through the end of the calendar year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided through the prescription drug component of the Plan administered by CVS Caremark for Network Benefits only.

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

The following table identifies what does and does not apply toward your applicable Network and non-Network Out-of-Pocket Maximum:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

Amounts that do not apply toward your Out-of-Pocket Maximum are always your responsibility to pay, even after you reach your Out-of-Pocket Maximum.

SECTION 3 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:
- An overview of the Personal Health Support program.
- Covered Health Services which Require Prior Authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this Benefit Booklet, the Personal Health Support program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card.

- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.

- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share

important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Prior Authorization

The Plan requires prior authorization for certain Covered Health Services. In general, your Network Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. For detailed information on the Covered Health Services that require prior authorization, please refer to Section 5, *Additional Coverage Details.*

It is recommended that you confirm with the Claims Administrator that prior authorization has been obtained for all Covered Health Services listed below as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services for which they fail to obtain prior authorization as required. You can contact the Claims Administrator by calling the number on the back of your ID card.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.
The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Network providers are generally responsible for obtaining prior authorization from the Claims Administrator or contacting Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible

for obtaining prior authorization from the Claims Administrator prior to receiving a service.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator as shown in Section 5, *Additional Coverage Details* before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if you do not obtain prior authorization from the Claims Administrator, as shown in Section 5, *Additional Coverage Details*.

The services that require prior authorization are:

- Ambulance - non-emergent air;
- Clinical Trials;
- Congenital heart disease surgery;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including breast pumps and diabetes equipment for the management and treatment of diabetes;
- Gender Dysphoria treatment as described under *Gender Dysphoria* in Section 5, *Additional Coverage Details*;
- Genetic testing - Breast Cancer Susceptibility Gene (BRCA);
- Home health care for nutritional foods and skilled nursing;
- Hospice care – inpatient;
- Hospital Inpatient Stay - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery;
- Lab, X-Ray and Diagnostics - Outpatient - sleep studies;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); Intensive Outpatient Program treatment; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management);
- Neurobiological Disorders - Autism Spectrum Disorder Services -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment facility); Intensive Outpatient Program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*;
- Private Duty Nursing – outpatient;
- Prosthetic devices;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance-Related and Addictive Disorders Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50

minutes in duration, with or without medication management; medication assisted treatment programs for substance-related and addictive disorders;
- Surgery - sleep apnea surgeries;
- Therapeutic treatments as described in Section 5, *Additional Coverage Details* under *Therapeutic Treatments - Outpatient*;
- Transplants.

For notification timeframes and any reductions in Benefits that apply if you do not obtain prior authorization or notify Personal Health Support, see Section 5, *Additional Coverage Details.*

Notification to Personal Health Support is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

(Applicable only to Medicare enrollees who have Plan coverage under COBRA or due to the receipt of long-term disability benefits under a Company-sponsored long-term disability plan).

If you are enrolled in Medicare on a primary basis, and Medicare pays benefits before the Plan, you are not required to obtain prior authorization before receiving Covered Health Services. Since Medicare pays Benefits first, the Plan will pay Benefits second as described in Section 9, *Coordination of Benefits (COB).*

SECTION 4 - PLAN HIGHLIGHTS

The table below provides an overview of the Plan's Annual Deductible, Out-of-Pocket Maximum and Lifetime Maximum Benefit.

Plan Features	Network	Non-Network
Annual Deductible[1]		
■ Individual	$2,500	$5,000
■ Family (cumulative Annual Deductible[2])	$5,000	$10,000
Annual Out-of-Pocket Maximum[1]		
■ Individual (enrolled in single coverage)	$5,000	$10,000
■ Individual (enrolled in family coverage)	$6,850	$20,000
■ Family (not to exceed the applicable Individual amount per Covered Person)	$10,000	$20,000
Lifetime Maximum Benefit[3] There is no dollar limit on the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

[1] Amounts you pay out-of-pocket that are counted toward the Annual Deductible also apply toward the Out-of-Pocket Maximum.

[2] If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in the table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits (other than Benefits for Network preventive care services and certain preventive medications and vaccines) until the family Deductible is satisfied.

[3] Generally the following are considered to be essential Benefits under the Patient Protection and Affordable Care Act:

Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details.*

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Acupuncture Services Acupuncture services will be reviewed after 20 visits for medical necessity	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ambulance Services		
■ Emergency Ambulance	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
■ Non-Emergency Ambulance	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Cancer Resource Services (CRS)[2] ■ Hospital Inpatient Stay See *Cancer Resource Services (CRS)* in Section 5, *Additional Coverage Details.*	80% after you meet the Annual Deductible	Not Covered
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a Network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each applicable Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Congenital Heart Disease (CHD) Surgery Services[2]	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services -Treatment of a Medical Condition	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Treatment Covered under Plan	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each applicable Covered Health Service category in this section.	
Diabetes Self-Management Items ■ Diabetes equipment (insulin pumps and pump supplies only). See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services – Outpatient	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Foot Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in your CVS Caremark Prescription Drug Benefit Booklet	
Home Health Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Kidney Resource Services (KRS)[2] (These Benefits are for Covered Health Services provided through KRS only)	80% after you meet the Annual Deductible	Not Covered
Lab, X-Ray and Diagnostics - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services		
■ Inpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Nutritional Counseling Up to 6 visits per condition per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Obesity Surgery[2] (The Plan pays Benefits only for Covered Health Services provided through BRS)	80% after you meet the Annual Deductible	Not Covered
Orthotic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	
Preventive Care Services		
■ Physician Office Services.	100%	60% after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Tests.	100%	60% after you meet the Annual Deductible
■ Breast Pumps.	100%	60% after you meet the Annual Deductible
■ Colonoscopy	1 at 100% every 10 years	60% after you meet the Annual Deductible
Private Duty Nursing - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment ■ Cardiac & Pulmonary Rehabilitation Services ■ All other services See *Rehabilitation Services-Outpatient Therapy* in Section 5, *Additional Coverage Details*, for limits	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 150 days per Covered Person per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Spine and Joint Surgeries MANDATORY In order to receive Spine and Joint Surgeries Benefits at a Designated Provider, you must contact a Spine and Joint Solution (SJS) Nurse and enroll in the SJS Program prior to surgery. An SJS Nurse may be reached by calling 1-877-214-2930.	80% after you meet the Annual Deductible when you use a Designated Provider	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Substance-Related and Addictive Disorders Services ■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services Any combination of Network and Non-Network Benefits for oral appliances and associated expenses are limited to a $1,500 maximum per Covered Person per lifetime	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible Note: Non-Network dialysis is not covered under the Plan.
Transplantation Services Non-Network Benefits include services provided at a Network facility that is not a Designated Provider and services provided at a non-Network facility.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	
Travel and Lodging (If services rendered by a Designated Provider)	For patient and companion(s) of patient undergoing transplant, obesity surgery, Spine and Joint Surgery services, cancer treatment or Congenital Heart Disease treatment	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Urgent Care Center Services	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible	Not Covered
Vision Examinations	*Routine Vision Examination:* 100% *Non-Routine Vision and refraction eye examination:* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Wigs Up to a $500 maximum per Covered Person per lifetime	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]You must obtain prior authorization from the Claims Administrator, as described in Section 3, *Personal Health Support and Prior Authorization,* to receive full Benefits for certain Covered Health Services. See Section 5, *Additional Coverage Details* for further information. In general, if you visit a Network provider, that provider is responsible for obtaining prior authorization from the Claims Administrator before you receive certain Covered Health Services. See Section 5 *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through BRS, CRS, CHD and KRS at a Designated Provider. For oncology services not provided through CRS or for congenital heart disease surgery services not provided through CHD, or for kidney services not provided through KRS the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient,* and *Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.* The Plan does not pay any Benefits for obesity surgery not provided through the BRS program.

SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call to obtain prior authorization.

This section supplements the second table in Section 4, *Plan Highlights*.

While the table in Section 4, *Plan Highlights* provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 7, *Exclusions and Limitations*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Acupuncture services will be reviewed after 20 visits for medical necessity.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal- directed services or if goals have previously been met.

Did you know...
You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 12, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services, please remember that you must obtain prior authorization from the Claims Administrator as soon as possible prior to the transport. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 12, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or a Personal Health Support Nurse.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Provider.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Clinical Trials

The Plan pays for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as determined by UnitedHealthcare, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*

- *Agency for Healthcare Research and Quality (AHRQ).*
- *Centers for Medicare and Medicaid Services (CMS).*
- A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*

- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.

- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgery Services

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD surgery services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the number on your ID card for information about these guidelines.

The Plan pays Benefits for Congenital Heart Disease (CHD) surgery services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility

charge and the charge for supplies and equipment. Benefits are available for the following CHD surgery services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by UnitedHealthcare to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you should contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD surgery services received at a Congenital Heart Disease Resource Services program.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises.
If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Dental Services - Accident Only

Accident only dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within 3 months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for accidental Injury for children. Timing of when the Covered Services will be rendered is determined by the Physician.

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).

- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Dental Services – Treatment of a Medical Condition

The Plan covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental treatment required as a result of a medical condition, but which is not an integral component of the treatment of that condition, is not covered (examples include decayed teeth due to dry mouth from medication or disease, or treatment of disease).

Dental Treatment Covered under Plan

The Plan provides Benefits for services provided by a duly licensed doctor, doctor of dental surgery or doctor of dental medicine for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, when the procedure is related to one of the following conditions:

- Congenital deformity, including cleft lip and cleft palate; and
- Removal of:
  - Tumors;
  - cysts which are not related to teeth or associated by dental procedures; and
  - exostoses for reasons other than preparation of dentures.

The Plan provides Benefits for dental implants and related procedures, such as bone grafting associated with the above three conditions.

In addition, Benefits may be provided for dentures and orthodontic braces if used to treat congenital deformity including cleft lip and cleft palate.

When any of the conditions listed above require surgical correction, Benefits for surgery will be subject to a Covered Health Service review to examine whether or not the condition

resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth.

In special cases, Benefits are only provided for anesthesia and facility charges related to dental procedures performed in a hospital or ambulatory surgical center. This Benefit is only available to dependent children below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating provider must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other dental services, including the charge for surgery, are not covered unless specifically covered by the Plan.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	■ Insulin pumps and pump supplies for the management and treatment of diabetes based upon the medical needs of the Covered Person. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Diabetic supplies such as monitors, syringes, test strips, and lancets are covered under the Plan's prescription drug benefit.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen;
- Equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- Delivery pumps for tube feedings;
- Breast pumps (only as provided under the Health Resources and Services Administration (HRSA) requirement);
- Negative pressure wound therapy pumps (wound vacuums);
- Burn garments;
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital – Inpatient Stay*, *Rehabilitation Services – Outpatient Therapy* and *Surgery – Outpatient* in this section;
- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part, cranial orthotics (helmets)for correction of positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets,

shoes/inserts made from a mold of a Covered Person's foot; Charges for custom built orthopedic shoes when medically necessary must be prescribed by a doctor and limited to two (2) pairs per calendar year;

- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage;

- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every five calendar years.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the five year timeline for replacement.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 2, *How the Plan Works.*

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within 48 hours of the admission or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Foot Care

The Plan covers hygienic and preventive maintenance foot care; cutting or removal of corns and calluses, nail trimming, cutting, or debriding only if the treatment is a Covered Health Service and related to a medical condition.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Services* in this section.

- Cross-sex hormone therapy:

  - Cross-sex hormone therapy administered by a medical provider (for example, during an office visit) is provided under *Pharmaceutical Products – Outpatient* in this section.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided under the Plan's prescription drug benefit.

- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

  - Clitoroplasty (creation of clitoris).
  - Labiaplasty (creation of labia).
  - Orchiectomy (removal of testicles).
  - Penectomy (removal of penis).
  - Urethroplasty (reconstruction of female urethra).
  - Vaginoplasty (creation of vagina).

  Female to Male:

  - Bilateral mastectomy or breast reduction.
  - Hysterectomy (removal of uterus).
  - Metoidioplasty (creation of penis, using clitoris).
  - Penile prosthesis.
  - Phalloplasty (creation of penis).
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries).
  - Scrotoplasty (creation of scrotum).
  - Testicular prosthesis.
  - Urethroplasty (reconstruction of male urethra).
  - Vaginectomy (removal of vagina).
  - Vulvectomy (removal of vulva).

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.

- Capacity to make a fully informed decision and to consent for treatment.
- Must be 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:

  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category in this section.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.

- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

- Not considered Custodial Care, as defined in Section 12, *Glossary*.

- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 12, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization for nutritional foods and skilled nursing, from the Claims Administrator five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-

based Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) services provided by Designated Providers participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 12, *Glossary.*

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Personal Health Support.
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.

- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography, including 3D mammograms (breast tomosynthesis) for screening or diagnosis of breast cancer.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirement
For Non-Network Benefits for sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement
For Non-Network Benefits for sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.
- Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management, you must obtain prior authorization for Non-Network Benefits before services are received.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.

- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits you must obtain prior authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout (a form of arthritis).
- Renal failure.
- Phenylketonuria (a genetic disorder diagnosed at infancy).
- Hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to six individual sessions per calendar year for each medical condition.

Obesity Surgery

(The Plan pays Benefits only for Covered Health Services provided through BRS)

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician if any of the following are true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea, hypertension, cardiopulmonary condition or diabetes) directly related to, or exacerbated by obesity.

In addition to meeting the above criteria the following must also be true:

- you have any life threatening or serious medical condition that is weight induced;
- a psychological examination of the Covered Person's readiness and fitness for surgery and the necessary postoperative lifestyle changes has been completed;

- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years;
- you have completed a 6-month Physician supervised weight loss program; and
- you have completed a pre-surgical psychological evaluation.

Coverage of surgical treatment of morbid obesity is limited to adults who are 18 years old or older.

You will have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program, as defined in Section 12, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling the toll-free number on the back of your ID card.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with obesity-related services received at a Designated Provider.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 12, *Glossary* and are not Experimental or Investigational or Unproven Services.

Please remember Non-Network Benefits for obesity surgery are not available.

Orthotic Devices

Refer to the Durable Medical Equipment (DME) section above for details.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-Ray and Diagnostics - Outpatient.*

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA. If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Please Note
Your Physician does not have a copy of your Benefit Booklet, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 6, *Clinical Programs and Services*, for details.

Preventive Care Services

The Plan pays Benefits for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

Examples of preventive care services include routine physical examinations, well-baby and well-child care, immunizations, screening mammograms and prostate screenings. Preventive care Benefits for women defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting or purchasing one breast pump per Pregnancy in conjunction with childbirth.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.

- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

Preventive care Benefits for women defined under the Health Resources and Services Administration (HRSA) requirement also include the following:

- Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes;
- Human papillomavirus testing in women with normal cytology results beginning at age 30 and no more frequently than once every three years;
- Annual counseling for sexually transmitted infections;
- Annual counseling and screening for human immune-deficiency virus;
- Comprehensive lactation support and counseling in conjunction with each birth, by a trained provider during pregnancy and/or in the postpartum period;
- All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, as prescribed by a doctor; and
- Annual screening and counseling for interpersonal and domestic violence.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining a breast pump that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), as defined in Section 12, *Glossary.*

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator for Private Duty Nursing – Outpatient visits. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every five calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are more than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry without regard to the lapse of time between the mastectomy and the reconstructive surgery. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 12, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedure is performed.
- A non-scheduled Reconstructive Procedure, you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy;
- Occupational therapy;
- Manipulative/Chiropractic Treatment;
- Speech therapy;
- Post-cochlear implant aural therapy;
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- Pulmonary rehabilitation; and
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- The services are ordered by a Physician and provided and administered by a licensed provider.

- The services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- The services require clinical training in order to be delivered safely and effectively.
- The services are not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. Rehabilitation services will be

reviewed after 40 visits for medical necessity. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Also, other than as described under Habilitative Services above, Physical therapy, Occupational therapy and Post-cochlear implant aural therapy will be reviewed after 40 visits for medical necessity.

Manipulative/Chiropractic Treatment will be reviewed after 20 visits for medical necessity.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient.* Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services.*

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12, *Glossary.*

Any combination of Network Benefits and Non-Network Benefits is limited to 150 days per Covered Person per calendar year.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency), you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Spine and Joint Solution (SJS) Program MANDATORY

The Spine and Joint Solution (SJS) program is for eligible participants age 18 and older. SJS provides support before, during, and after surgery. Nurses help direct participants to high-quality facilities and provide them case management support.

In scope procedures include:

- Spine Fusion Inpatient Surgery.
- Disc Inpatient Surgery.
- Total Hip Replacement Inpatient Surgery.
- Total Knee Replacement Inpatient Surgery.

If care involves a hospital admission, it may also require that surgery is performed at an SJS Center of Excellence (COE) facility (Designated Provider). To enroll in the program and find the closest COE provider, call 1-877-214-2930 and ask to speak with an SJS Nurse.

You must enroll in the SJS Program to access benefit coverage for spine and joint procedures. Failure to enroll in the program may result in no coverage for your spine & joint procedure.

Enhanced travel benefits may be available to participants who enroll in this program and utilize a Center of Excellence (COE) facility (Designated Provider) for their eligible surgery. See *Travel and Lodging* for details.

As part of the SJS program, most facilities will cover costs related to complications that result from the surgery for a period of 90 days after the surgery. Claims incurred during this period of time will be reviewed to determine if they were a complication related to the surgery or a readmission to the COE and, as a result, if this feature applies.

Benefits are available for spine and joint services that meet the definition of a Covered Health Service, as defined in Section 12, *Glossary* and are not Experimental or Investigational or Unproven Services.

Please remember Non-Network Benefits for inpatient spine and joint surgery are not available.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/ Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember, for Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance-related and addictive disorders.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement
For Non-Network Benefits for sleep apnea surgery, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration (FDA)*-approved TMJ implants only when all other treatment has failed.

Any combination of Network Benefits and Non-Network Benefits for oral appliances and associated expenses is limited to a $1,500 maximum per Covered Person per lifetime.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis* (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

*Non-Network dialysis is *not* covered under the Plan.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement
For Non-Network Benefits for the following outpatient therapeutic services, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MRI guided focused ultrasound.

If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

The Plan pays Benefits for organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Designated Provider, Network facility that is not a Designated Provider or a non-Network facility.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
For Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Provider, Network Benefits will not be paid. Non-Network Benefits will apply.

For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

For non-Network Benefits, if you don't obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Travel and Lodging Assistance Program

Travel and Lodging assistance is available under the Plan for you or your eligible family member only if you meet the qualifications for the benefit, including receiving care at a Designated Provider that is more than 50 miles from your home address. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all

transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

- The SJS services program provides a maximum of $2,000 per Covered Person per procedure for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 12, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section. Benefits under this section are not available for services to treat a condition that does not meet the definition of Urgent Care.

Virtual Visits

The Plan provides Benefits for virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Vision Examinations

The Plan pays Benefits for:

- Vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment).
- One routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every calendar year.
- Non routine vision exam and refraction eye exam –(*Vision Exam* - medical/surgical eye care is typically problem-oriented, involving the use of medication and/or surgical procedures to diagnose and treat eye problems, such as glaucoma, pink eye and cataracts. *Refractive eye exam* – external and internal exam, neurological integrity, pupillary reflexes, versions, biomicroscopy, tonometry, visual acuity, subjective, refraction, accommodative function, binocular function).

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from treatment of malignancy or permanent loss of hair from an accidental injury.

Any combination of Network Benefits and Non-Network Benefits is limited to a $500 maximum per Covered Person per lifetime.

SECTION 6 - CLINICAL PROGRAMS AND SERVICES

What this section includes:
Health and well-being resources available to you, including:
- Condition Management Services; and
- Telephonic Wellness Coaching.

The Company believes in giving you the tools you need to be an educated health care consumer. To that end, the Company has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the Company are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that the Company has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drug products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are available when you log onto www.myuhc.com;
- search for Network providers available in your Plan through the online provider directory;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information;
- view and print all of your Explanations of Benefits (EOBs) online; and

- order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports Covered Persons who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 5, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS).*

Condition Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a condition management program at no cost to you. The heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition. These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;

- access to educational and self-management resources on a consumer website;

- an opportunity for the condition management nurse to work with your Physician to ensure that you are receiving the appropriate care; and

- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:

  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate Covered Persons and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 12, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Telephonic Wellness Coaching

The following provides a description of and the eligibility criteria for each Wellness Coaching program:

Tobacco Cessation Program

A tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support throughout the quitting process for up to one year via toll-free phone and live chat.
- Nicotine replacement therapy (patch, lozenge or gum) sent to you in conjunction with your quit date.
- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in the Quit For Life® program, or if you would like additional information regarding the program and also how to access the program online, please call the number on the back of your ID card.

Stress Management Program

UnitedHealthcare's stress management program will provide you with information to help you manage stress through positive behavioral changes.

UnitedHealthcare will identify Covered Persons who are eligible for the stress management program based on the following criteria:

- Covered Persons who feel tense, anxious, or depressed often and stress has had a noticeable impact on health a lot over the past year.

Nutrition Management Program

UnitedHealthcare's nutrition management program will provide you with information designed to increase your awareness of the importance of proper nutrition, and setting dietary goals, and making lifestyle changes. UnitedHealthcare will identify Covered Persons eligible for the nutrition management program based on the following criteria:

- Covered Persons having a BMI of greater than or equal to 25 and less than 30 and 5-6 servings of high cholesterol food per day. BMI greater than or equal to 30 is prioritized to the weight management program.

Exercise Management Program

UnitedHealthcare's exercise management program will provide you with information to assist you in developing an appropriate exercise regime, giving consideration to factors such as age, weight and other health-related conditions. UnitedHealthcare will also provide exercise educational materials. UnitedHealthcare will identify Covered Persons eligible for the exercise management program based on the following criteria:

- Covered Persons with a BMI of greater than or equal to 25 and less than 30 and have physical activity less than one time per week. BMI greater than or equal to 30 is prioritized to the weight management program.

Heart Health Lifestyle Management Program (Blood Pressure/Cholesterol)

The heart health lifestyle management program provides you with an overall understanding of the factors that affect heart health, such as blood pressure and cholesterol. You receive assistance in making lifestyle changes to reduce risks, in addition to guidance on factors that increase risks, such as lack of proper nutrition and exercise. The identification/stratification criteria for the heart health lifestyle management program are as follows:

- self-report excess weight with a BMI > 25; or
- Covered Person has at least one of the following risk criteria:
  - systolic BP = >/=140 or Diastolic BP = ./=90
  - high Blood Pressure and is on medication
  - cholesterol = 240 or HDL < 40
  - indicates has high cholesterol & is on medication
  - high LDL
  - indicates has heart problems, but no heart failure
- BMI greater than or equal to 30 is prioritized to the weight management program.

Diabetes Lifestyle Management Program

The diabetes lifestyle management program is designed to educate you on proper diet, weight loss/management and exercise. You receive educational materials and guidance focused on prevention through diet, weight loss management, exercise and, when applicable, compliance with prescribed medication. The identification/stratification criteria for the diabetes lifestyle management program are as follows:

- Covered Persons who indicate they have diabetes and self-report excess weight with a BMI > 25. BMI greater than or equal to 30 is prioritized to the weight management program.

Wellness Programs

Real Appeal Program

UnitedHealthcare provides the Real Appeal program, which represents a practical solution for weight-related conditions, with the goal of helping people at risk from obesity-related

diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Coinsurance or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325). TTY users can dial 711 or visit **www.realappeal.com**.

Healthy Pregnancy Program

If you are pregnant and enrolled in the Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 7 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 5, *Additional Coverage Details.*

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 4, *Plan Highlights.* Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 4, *Plan Highlights.* Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the Benefit Booklet says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Benefit Booklet specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing (holistic tissue massage).
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health.*

This exclusion does not apply to Manipulative/Chiropractic Treatment and non-manipulative/chiropractic osteopathic care for which Benefits are provided as described in Section 5, *Additional Coverage Details.*

Dental

1. Dental implants or root canals, orthodontic braces, removal of teeth and intra-bony cysts, procedures performed for the preparation of the mouth for dentures, except as identified under *Dental Treatment Covered under Plan* in Section 5, *Additional Coverage Details.*

2. Treatment for the following conditions:
   - injury related to chewing or biting;
   - preventive dental care, diagnosis or treatment of or related to the teeth or gums;
   - periodontal disease or cavities and disease due to infection or tumor.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement.

For information on your dental coverage, contact your Dental Plan provider.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

3. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen prosthetic devices.

5. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details.*

6. Oral appliances for snoring.

7. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details.*

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill (See your CVS Caremark Prescription Drug Benefit Booklet for information about the Plan's prescription drug benefit).

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Clomiphine (e.g., Clomid®), menotropins (e.g., Repronex®), or other drugs associated with conception by artificial means.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

2. Treatment of flat feet.

3. Treatment of subluxation of the foot.

4. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.
   - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
   - Voice modification surgery.
   - Voice lessons and voice therapy.

2. Reversal of tubal ligation or vasectomy.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - Compression stockings, ace bandages, diabetic strips, and syringes.

   This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in Section 5, *Additional Coverage Details.*
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details.*
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *Additional Coverage Details.*

2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen Durable Medical Equipment.

5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 5, *Additional Coverage Details.*

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 7, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 5, *Additional Coverage Details.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder.

4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Transitional Living services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements,

electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Food of any kind. Foods that are not covered include:

   - nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Food is covered only when the sole source of nutrition and administered via enteral feeding (tube feeding). Infant formula available over the counter is always excluded;
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

3. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement;
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.
   - Motorized beds, non-Hospital beds, comfort beds and mattresses.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.

- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 12, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs regardless of the reason for the hair loss except for treatment of malignancy or permanent loss of hair from an accidental injury, in which case the Plan pays up to a maximum of $500 per Covered Person per lifetime; and;

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer).

3. Rehabilitation services and Manipulative/Chiropractic Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders.

5. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy* in Section 5, *Additional Coverage Details.*

6. A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy.

7. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

8. Psychosurgery (lobotomy).

9. Treatment of tobacco dependency, excluding screenings and counseling.

10. Chelation therapy, except to treat heavy metal poisoning.

11. Manipulative/chiropractic Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies.

12. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

13. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 5, *Additional Coverage Details* and the other requirements described under *Obesity Surgery* in Section 5, *Additional Coverage Details,* are satisfied;.

14. Medical and surgical treatment of excessive sweating (hyperhidrosis).

15. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan

or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.

16. Breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details.*

17. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

    - Has not been actively involved in your medical care prior to ordering the service.
    - Is not actively involved in your medical care after the service is received.

    This exclusion does not apply to mammography.

6. Services and supplies provided at Cancer Treatment Centers of America are not covered under the Plan.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

    This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue).

4. The reversal of voluntary sterilization.

5. The reversal of tubal ligation or vasectomy.

6. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.

7. Health services and associated expenses for elective surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

8. Services provided by a doula (labor aide).

9. Parenting, pre-natal or birthing classes.

10. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 9, *Coordination of Benefits (COB).*

2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you.

3. While on active military duty.

4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except as identified under *Transplantation Services* in Section 5, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 5, *Additional Coverage Details.* Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details.*

Types of Care

1. Custodial Care as defined in Section 12, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 12, *Glossary.*

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Provider concierge services.

5. Private Duty Nursing received on an inpatient basis.

4. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details.*

5. Rest cures.

8. Services of personal care attendants.

9. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

4. Eye exercise or vision therapy.

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan.
   - That exceed Eligible Expenses or any specified limitation in this Benefit Booklet
   - For which a non-Network provider waives the Annual Deductible or Coinsurance amounts.

6. Foreign language and sign language services.

7. Long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

10. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

11. Health services and supplies that do not meet the definition of a Covered Health Service as defined in Section 12, *Glossary.* Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Benefit Booklet under Section 5, *Additional Coverage Details* and in Section 4, *Plan Highlights.*
    - Not otherwise excluded in this Benefit Booklet under this Section 7, *Exclusions and Limitations.*

SECTION 8 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Deductible or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or by visiting the Duke Energy Portal. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:

- The Current Procedural Terminology (CPT) codes.
- A description of, and the charge for, each service.
- The date the Sickness or Injury began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Duke Energy and the Plan reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes Duke Energy or the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 9. *Coordination of Benefits.*

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.

- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the following:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the denial;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- a description of the Plan's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action;
- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;

- if an internal rule, guideline, protocol or other similar criterion was relied on in making the denial, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request;

- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- in the case of a denial concerning an Urgent Care claim, a description of the expedited review process applicable to such claims; and

- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 12, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 18 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 18 month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

This section describes what happens if a claim for Benefits is denied, how you can appeal a denied claim and the first and second level internal appeals processes. At the end of this section is a table which describes the time frames that you and UnitedHealthcare are required to follow in connection with the internal claims and appeals processes.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a concurrent claim determination, including a rescission of coverage, as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 740809
Atlanta, Georgia 30374

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:
- Urgent Care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal, and will take into account all comments, documents, records and other information you submit relating to your claim for Benefits, without regard to whether such information was submitted or considered in the initial denial. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

To the extent required by applicable law, UnitedHealthcare will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan (or at the direction of the Plan) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, to the extent required by applicable law, if the denial of your appeal is based on a new or additional rationale, UnitedHealthcare will provide you, free of charge, with the new or

additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. The written explanation will include the following:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination of your appeal;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the determination of your appeal is based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim;
- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate the external appeal process;
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action, and about any available voluntary alternative dispute resolution options;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request;
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination. UnitedHealthcare must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and within 30 days after receiving the completed post-service appeal. Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial which will include the information specified above with respect to your first appeal, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. UnitedHealthcare's decision will be final, unless overturned through the Federal External Review Program described below.

Once you have exhausted the internal claims and appeals process described above, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. See "Federal External Review Program" below for additional information.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims and appeals, depending on the type of claim or appeal. There are three types of claims and appeals:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service claim- a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal a denied Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal

You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal
*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.	
Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment

was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision. If you do not submit a request for standard external review within four months after the date you received UnitedHealthcare's decision, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was requested or provided.
- Did not have the claim denied due to a failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is complete but is not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Department of Labor's Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials necessary to make the request complete. You must provide the required information to UnitedHealthcare within the original four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If you do not provide the required information by the applicable deadline, the claim will be deemed permanently waived and abandoned and you will be precluded from reasserting it under these procedures.

If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the

external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, the IRO considered in reaching its decision;
- a discussion of the principal reason or reasons for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral

will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.

- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.

- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you as described above with respect to the Standard External Review Process. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the

final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator unless you first complete all the steps in the internal appeal processes described in this section. After completing this process, if you want to bring a legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator, you must do so within one year following a final decision on the claim under the internal appeal processes or you lose any rights to bring such an action against the Company, the Plan, the Plan Administrator or the Claims Administrator.

SECTION 9- COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term "allowable expense" is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.

- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.

- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:

  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.

- Plans for active employees pay before plans covering laid-off or retired employees.

- The plan that has covered the individual claimant the longest will pay first.

- Only expenses normally paid by the Plan will be paid under COB.

- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, the Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan may pay an additional amount.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two plans' reasonable and customary charges. If the Plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare.*

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older;
- Individuals with end-stage renal disease, for a limited period of time; and
- Participants not actively working and receiving long-term disability benefits for up to six months.
- After a participant who is not actively working has received long-term disability benefits for six months, the Plan will pay Benefits second to Medicare.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare.

If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable

expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carrier have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. This cross-over process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan.

The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.

- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's

express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.

- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to your own negligence.

- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party, filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you or your dependents, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been contributed to or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 11 - OTHER IMPORTANT INFORMATION

What this section includes:

- Your relationship with UnitedHealthcare and the Company.
- Relationships with providers.
- Incentives to providers and you.

Your Relationship with UnitedHealthcare and the Company

In order to make choices about your health care coverage and treatment, the Company believes that it is important for you to understand how UnitedHealthcare interacts with the Plan and how it may affect you. UnitedHealthcare helps administer the Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The Company and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this Benefit Booklet).
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between the Company, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not the Company's agents or employees, nor are they agents or employees of UnitedHealthcare. The Company and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees, agents or employees of Network providers.

The Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the Company and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Company's employees

nor are they employees of UnitedHealthcare. The Company and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. The Company and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employee of the Company for any purpose with respect to the administration or provision of benefits under this Plan.

The Company and the Plan Administrator are solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination of or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as a participant responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.

Information and Records

UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. UnitedHealthcare may request additional information from you to decide your claim for Benefits. UnitedHealthcare will keep this information confidential.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan Administrator and UnitedHealthcare with all information or copies of records relating to the services provided to you. The Plan Administrator and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents. The

Plan Administrator and UnitedHealthcare agree that such information and records will be considered confidential.

The Plan Administrator and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan Administrator is required to do by law or regulation. During and after the term of the Plan, the Plan Administrator and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements you should contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary.

UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.

- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but you should discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for

any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

SECTION 12 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this Benefit Booklet.

Many of the terms used throughout this Benefit Booklet may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefit Booklet, but it does not describe the Benefits provided by the Plan.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year (other than Benefits for Network preventive care services which are paid at 100% by the Plan even before you satisfy your Annual Deductible). The Deductible is shown in the first table in Section 4, *Plan Highlights*.

Annual Enrollment - the period of time, determined by Duke Energy, during which eligible Employees may enroll themselves and their Dependents under the Plan. Duke Energy determines the period of time that is the Annual Enrollment period.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The BRS program provides:

- Specialized clinical consulting services to Covered Persons to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The CRS program provides:

- Specialized consulting services, on a limited basis, to Covered Persons with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works.*

Company - Duke Energy Corporation and its affiliated companies that are participating in the Plan.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health coverage to certain employees and their dependents whose group health coverage has been terminated.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this Benefit Booklet under Section 4, *Plan Highlights* and Section 5, *Additional Coverage Details.*
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in the General Information Booklet.
- Not otherwise excluded in this Benefit Booklet under Section 7, Exclusions and Limitations.

Covered Person – the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person. For purposes of the wellness programs described in Section 6. *Clinical Programs and Services*, "Covered Person" means all domestic Employees who are eligible for the Plan, their Dependents age 18 and over who are eligible for the Plan and each other person who is eligible for the Plan and elects to participate in the wellness program, regardless of whether such person also elects to participate in the Plan.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the General Information Booklet.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by UnitedHealthcare as stated below and as detailed in Section 2, *How the Plan Works.*

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy

guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Employee – an individual who meets the eligibility requirements described in the General Information Booklet.

Employer - Duke Energy Corporation.

EOB - see Explanation of Benefits (EOB).

ERISA – the Employee Retirement Income Security Act of 1974 (ERISA), the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)

- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section 5, Additional Coverage Details.

- If you are not a participant in a qualifying Clinical Trial as described under Section 5, Additional Coverage Details, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).

- The allowable reimbursement amounts.

- Deductibles.

- Coinsurance.

- Any other reductions taken.

- The net amount paid by the Plan.

- The reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:

  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

- Diagnostic criteria for children:

  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - A strong dislike of ones' sexual anatomy.

- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA), The Denver Model,* and *Relationship Development Intervention (RDI).*

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The KRS program provides:

- Specialized consulting services to Covered Persons with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative/Chiropractic Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Sickness, Injury, Mental Illness, substance related and addictive disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Sickness, Injury, Mental Illness, substance related and addictive disorder, disease or its symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Services Administrator- the organization or individual designated by the Plan Administrator who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 7, *Exclusions and Limitations*.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 4, *Plan Highlights* and Section 2, *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 4, *Plan Highlights* and Section 2, *How the Plan Works*, for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - the maximum amount you pay every calendar year. Refer to Section 4, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 2, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Health Savings Plan 1 Option under the Duke Energy Active Medical Plan and/or the Duke Energy Active Medical Plan, as appropriate depending on context, each as amended from time to time.

Plan Administrator – The Duke Energy Benefits Committee or its designee.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.

- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.

- It provides at least the following basic services in a 24-hour per day, structured milieu:

  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan Coinsurance and Deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Benefit Booklet includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.

- A Physician orders them.

- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.

- They require clinical training in order to be delivered safely and effectively.

- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Spouse – your spouse or domestic partner as defined in the General Information Booklet.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program – a program that identifies network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.

- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your Claims Administrator.

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ አንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة تعريف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հէոախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mobangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនគិតថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខដែលចេញនៅលើ សំរាប់សមាជិក ដែលមានឈ្មោះនៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꮻ ÞP ᏗCZᎮᏗ Ꮧ4ᏫᎠᏗ ᏂᎪᏭᏔW it ᏩᏙP ᏁᏋ ÞR ᏗJᎯᏁᏗ ACᏫᎠᏁᏗ ᎢΘᏂᏫᎠᏗT, ᏙᏊᏫᏯᏫᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。
28. Karen	[illegible] 0 [illegible] TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو نای دی کارتی پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຜ່ານໝາຍເລກໂທລະສັບສຳລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.

Language	Translated Taglines
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit['iz7 'ats'77s bee baa'ahay1 bee n44hozin7g77 bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711

Language	Translated Taglines
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	[illegible] TTY 711. 0
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711

Language	Translated Taglines
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá òǵbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ‘0’. TTY 711

DUKE ENERGY ACTIVE MEDICAL PLAN HEALTH SAVINGS PLAN 1 OPTION

CVS caremark™

Prescription Drug Program Guide for the Duke Energy Active Medical Plan

TABLE OF CONTENTS

SECTION 1 – WELCOME

The Duke Energy Active Medical Plan ("Medical Plan") options include outpatient prescription drug coverage currently administered by CVS Caremark. CVS Caremark works with Duke Energy Corporation ("Duke Energy") (individually or collectively referred to with its affiliated companies as the "Company," as appropriate) to help you improve your health and make informed health care decisions, as well as save money on your prescription drugs.

Your prescription drug program benefits through CVS Caremark include the following features:

- The CVS Caremark retail network consists of more than 64,000 participating retail pharmacies.
- Your long-term prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy.
- Online resources are available at **www.Caremark.com** to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- You can reach CVS Caremark Customer Service representatives, 24 hours a day, 7 days a week at 888-797-8912. Pharmacists are also available around the clock for medication consultations.

CVS Caremark will help protect your privacy as follows:

- CVS Caremark employees follow detailed ethical standards and a comprehensive Code of Conduct regarding your personal health information.
- CVS Caremark pharmacists follow a professional Code of Ethics.

SECTION 2 – HOW THE PROGRAM WORKS

Prescription Drug Coverage under the Health Savings Plan (HSP) Options

Because you are enrolled in a Health Savings Plan (HSP) option under the Medical Plan, you pay 100% of CVS Caremark's negotiated price for your prescription drug purchases (other than preventive medications, as described below) at retail pharmacies and through the CVS Caremark Mail Service Pharmacy until you meet the applicable Medical Plan annual deductible under your HSP option[1].

If you use a pharmacy that is participating in the CVS Caremark retail network, once you meet your applicable annual deductible, the HSP option pays eligible prescription drug expenses at 80% coinsurance and you pay 20% until you reach the applicable Medical Plan annual out-of-pocket maximum under the HSP option. If you use a pharmacy that is not participating in the CVS Caremark retail network, once you meet your applicable annual deductible, the HSP option pays eligible prescription drug expenses at 60% coinsurance and you pay 40% until you reach the applicable Medical Plan annual out-of-network, out-of-pocket maximum under the HSP option. The applicable annual out-of-pocket maximum under the HSP option is a combined out-of-pocket maximum that applies to both medical and prescription drug expenses under the Medical Plan. After you reach the applicable annual out-of-pocket maximum, the HSP option pays 100% of your eligible prescription drug purchases for the remainder of the calendar year.

If you use any medications on a long-term basis, ordering your medications through the CVS Caremark Mail Service Pharmacy may still help you maximize savings.

Remember: Under the HSP option, your eligible medical expenses and your eligible prescription drug purchase amounts apply to the HSP option's annual deductible and you pay 100% of your eligible expenses (excluding certain preventive care services and preventive medications) until you reach the deductible.

As you make prescription drug purchases for each covered individual, the receipts you receive can help you track your progress toward meeting the annual deductible. You may also call CVS Caremark Customer Service to determine the portion of the deductible that has been satisfied to date.

[1] *For in-network benefits under the HSP option, you must satisfy an annual individual deductible if only you are covered or an annual family deductible if one or more of your eligible dependents also is covered.*

Filling Your Prescription at a Pharmacy Participating in the CVS Caremark Retail Network

You can fill a prescription for up to a 30-day supply at any of over 64,000 retail pharmacies participating in the CVS Caremark retail network. You will simply show your CVS Caremark prescription ID card at the time of your purchase. You will pay 100% of your non-preventive prescription drug purchases until you meet the applicable Medical Plan annual deductible under your HSP option, after which you pay a coinsurance amount. Once you meet the applicable Medical Plan annual out-of-pocket maximum under your HSP option, the Medical Plan pays for your eligible prescription drug purchases at 100%.

- If you don't identify yourself to the pharmacist as a CVS Caremark participant, or if you go to a pharmacy that is not participating in the CVS Caremark retail network, you will have to pay the full price for non-preventive prescription drug purchases, even if you have already met the applicable Medical Plan annual deductible or annual out-of-pocket maximum under your HSP option, when you pick up the prescription and then submit a paper claim to CVS Caremark for reimbursement. You will be reimbursed based on the CVS Caremark negotiated price for the medication, less any required deductible and coinsurance. Retail pharmacies that participate in the CVS Caremark retail network fill prescriptions at an agreed upon discounted price. When you fill prescriptions at a non-participating retail pharmacy, or do not identify yourself as a CVS Caremark participant, you may be charged a price higher than the negotiated price and the result is a higher cost prescription to you.
- If you make a non-preventive prescription drug purchase at a pharmacy that is participating in the CVS Caremark retail network, do not identify yourself as a CVS Caremark participant by presenting your CVS Caremark prescription ID card and are required to pay full price for the non-preventive prescription drug purchase, generally, you have up to 14 days from the time your prescription was purchased to return to the pharmacy, present your CVS Caremark prescription ID card and ask the pharmacist to submit the order using the original dispensing date. Please confirm at the time you make your purchase that you can return to have your purchase re-processed. You may be entitled to a refund for the difference between the full price and your applicable deductible and coinsurance. This process will eliminate your need to submit a paper claim to CVS Caremark for reimbursement.

Using the CVS Caremark Maintenance Choice™ Program

Generally, a long-term (maintenance) medication is one that you take on a long-term basis such as those used for diabetes, asthma, high blood pressure, high cholesterol or birth control. If you are taking a long-term (maintenance) medication, you may request that your doctor prescribe 90-day supplies, plus refills as appropriate (three refills maximum) instead of 30-day supplies. Under CVS Caremark's Maintenance Choice program, if you choose to receive 90-day supplies, you must fill your prescription through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy near you.

Fill limit for long-term medications

The Medical Plan allows three 30-day fills of long-term medications at any pharmacy that participates in the CVS Caremark retail network. After that, the Medical Plan will cover long-term medications only if you have 90-day supplies filled through the CVS Caremark Mail

Service Pharmacy or at a CVS retail pharmacy at the applicable 90-day supply coinsurance amount. If you do not use the CVS Caremark Mail Service Pharmacy or a CVS retail pharmacy after the third fill, you will pay 100% of the retail price of the long-term medication.

If you will be obtaining your own prescription, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum).

The list of long-term medications that are part of the Maintenance Choice program is subject to change at any time. Visit **www.Caremark.com** to find out whether your medication is considered a long-term medication and whether it is affected by any Medical Plan limits, or you may call CVS Caremark directly for more information.

Process for Mail Order Medications
There are several methods you may use to fill your newly prescribed long-term medications through the CVS Caremark Mail Service Pharmacy.

- **Option 1**: Ask your doctor to select the CVS Caremark Mail Service Pharmacy using their provider ePrescribing tools, or your physician may call 800.378.5697.

- **Option 2**: Use the CVS Caremark mobile app for your smart phone to photograph your prescription order and submit the new prescription electronically to the CVS Caremark Mail Service Pharmacy.

- **Option 3**: Get started using the CVS Caremark Mail Service Pharmacy with FastStart®. Log on to www.caremark.com/faststart to provide the requested information, and CVS Caremark will contact your doctor for the 90-day prescription you need. You also can call FastStart® toll-free at 800.875.0867 for assistance.

- **Option 4**: Alternatively, you can complete the mail order form, which is available at www.Caremark.com, and send it with your new prescription order and payment method for any applicable prescription drug annual deductible and co-insurance amounts to the address on the form. If you have any questions about completing the form, contact Customer Service at 888-797-8912.

Once you fill a prescription through the CVS Caremark Mail Service for the first time, you then have the option to use the automated refill service for future refills by CVS Caremark. Visit www.Caremark.com for more information on the Auto Refill process.

Please note: When a prescription is ordered using the CVS Caremark Mail Service Pharmacy, CVS Caremark will automatically dispense the generic equivalent if one is available and permissible by law, unless your physician has indicated that substitution is not allowed.

Using Mail Order if you have an Immediate Medication Need
If you will be using the CVS Caremark Mail Service Pharmacy, but need to begin taking a long-term medication immediately, have your doctor write two prescriptions:

- The first for up to a 30-day supply to be filled right away at any pharmacy that is participating in the CVS Caremark retail network – your doctor can call/fax this prescription to the pharmacy or provide it to you so you may take it to the pharmacy.
- The second for up to a 90-day supply to be filled through the CVS Caremark Mail Service Pharmacy using one of the methods described above.

Covered Expenses

The following are covered expenses under the Medical Plan unless listed as excluded below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes
- Glucose Monitors
- Over-the-Counter (OTC) Diabetic Supplies (lancets, lancet devices, alcohol wipes)
- Oral, Transdermal, Intravaginal and Injectable Contraceptives
- Contraceptive Emergency kits
- Drugs to Treat Impotency (Limits of 6 units per 30 days at retail, and 18 units per 90 days at mail for all dosage forms except Yohimbine)
- Inhaler Assisting Devices
- Peak flow meters
- Fertility Agents (100% after deductible, if applicable, up to $2,500 per person per lifetime, then participant pays 50% of the cost of the drug)
- Influenza treatments at 1 treatment course per 180 days
- Zyban and Chantix (limit of 360 days of therapy per lifetime)
- Anti obesity Agents
- Products packaged as greater than a 30-day supply are covered through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy only

Excluded Expenses

The following are excluded from coverage under the Medical Plan unless specifically listed as a benefit under "Covered Expenses."

- Non-Federal Legend Drugs
- Non-systemic contraceptives, devices
- Smoking Deterrents (except as listed above)
- Nutritional Supplements
- Ostomy Supplies (covered as a medical expense under the Medical Plan)
- Glucowatch Products
- Mifeprex
- Therapeutic devices or appliances (including Diabetic Pumps and supplies, which are covered as a medical expense under the Medical Plan)
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums (covered as a medical expense under the Medical Plan)

- Biologicals, immunization agents or vaccines (except as noted below for certain routine vaccines)
- Blood or blood plasma products (covered as a medical expense under the Medical Plan)
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or from any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the participant
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug
- New-to-market unapproved products and certain existing unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act (FFDCA)
- Arestin (covered as a dental expense under the Duke Energy Active Dental Plan)

Medical Plan and Health Savings Account

If you have established a Health Savings Account and sufficient funds are available in your account, you may choose to pay any prescription drug annual deductible and coinsurance amounts with before-tax dollars by using your HSA debit card or checkbook.

Medical Plan and Health Care Spending Account

If you have enrolled in a Health Care Spending Account (HCSA) and are eligible to access HCSA funds, you may pay any prescription drug annual deductible and coinsurance amounts with before-tax dollars by filing for reimbursement from your HCSA or using your HCSA debit card.

SECTION 3 – COVERAGE DETAILS

CVS Caremark Primary/Preferred Drug List

Your cost for prescription purchases will vary depending on whether your physician prescribes a generic, preferred brand or non-preferred brand medication. By asking your physician to prescribe generic or preferred brand medications, you can help control rising health care costs.

Your prescription drug program incorporates a Primary/Preferred Drug List which lists the Medical Plan's preferred brand medications. The medications included on the list, which change from time to time, are commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings for the participant and the Medical Plan. For the most recent listing and to find out whether a medication is included in the Primary/Preferred Drug List, visit CVS Caremark online at **www.Caremark.com** or call CVS Caremark Customer Service at 888-797-8912. This listing is also available for viewing by employees on the Duke Energy Portal.

Refer to the prescription drug program summary of benefits on page 21 for more information about applicable coinsurance amounts for generic, preferred brand and non-preferred brand medications.

Preventive Medications

CVS Caremark maintains a list of certain medications prescribed to prevent the occurrence/re-occurrence of chronic illnesses. This list is referred to as the Preventive Therapy Drug List. Under your HSP option, preventive medications included on the Preventive Therapy Drug List are covered at 100% and are not subject to your HSP option's co-insurance or deductible when you use either a pharmacy that is participating in the CVS Caremark retail network or the CVS Caremark Mail Service Pharmacy to fill those prescriptions. This means that the Medical Plan will cover 100% of the cost and you will pay nothing, even if you have not met the applicable Medical Plan annual deductible.

Preventive medications are those items used to address risk factors for a disease that has not yet manifested itself, or to prevent the reoccurrence of a disease. Preventive medications do not include drugs for treatment of an existing illness or condition. A copy of the current Preventive Therapy Drug List is available on **www.Caremark.com**. CVS Caremark develops the Preventive Therapy Drug List in accordance with FDA and IRS guidelines regarding the types of medications that are considered "preventive" and therefore may be covered under your HSP option before the required deductible is satisfied. The Preventive Therapy Drug List is periodically updated to reflect new guidance issued and/or new drugs on the market.

Certain Contraceptive Medications Covered at 100%

The following contraceptive medications are covered at 100% (i.e., you do not pay anything when you purchase these items) when received from a pharmacy that is participating in the CVS Caremark retail network or the CVS Caremark Mail Service Pharmacy:

- Generic contraceptive medications; and

- Brand contraceptive medications where there is no generic available.

Note: If a generic version of a brand contraceptive medication becomes available, then only the generic contraceptive medication will be covered at 100%.

Certain Routine Vaccines Covered at 100%

The Medical Plan provides coverage for certain commonly administered vaccines at 100% when you present your CVS Caremark prescription ID card at a pharmacy that is participating in the CVS Caremark retail network. This is an alternative to getting certain immunizations from your doctor. Commonly administered vaccines available at a participating pharmacy through the Medical Plan include the following, where applicable:

- Hepatitis A (Adult)
- Hepatitis A (Child)
- Hepatitis B (Adult)
- Hepatitis B (Child)
- Human Papillomavirus (Gardasil)
- Influenza (Fluzone)
- Meningitis
- MMR (Measles, Mumps, Rubella)
- Pneumonia (Pneumovax)
- Polio (IPV)
- Shingles vaccine (Zostavax)
- TD (Tetanus, Diphtheria)
- Tdap (Tetanus, Diphtheria, Pertussis)

Please Note: Not all local pharmacies are staffed to provide immunizations and some may require a prescription to administer the vaccine based on requirements of particular states. Check with your local pharmacy for vaccine availability before you go.

CVS Caremark Specialty Medications and Specialty Guideline Management

Duke Energy participates in the CVS Caremark Specialty Guideline Management Program. This program supports safe, clinically appropriate and cost-effective use of specialty medications. Under your prescription drug program, some specialty medications may only be covered when ordered through CVS Caremark's specialty care pharmacy. CVS Caremark is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling.

Certain specialty medications such as treatments for Growth Hormone and related disorders, Hepatitis C, Multiple Sclerosis and Anemia will have additional management that ensures that the specialty medication continues to have appropriate lab testing and data reviewed to help ensure utilization of these specialty medications to be:

- clinically appropriate;
- safe; and

- effective for the patient throughout the duration of therapy.

For continued treatment with one of these specialty drugs, a periodic clinical review is required. CVS Caremark will obtain the necessary clinical information from your doctor's office and conduct the review.

The CVS Caremark Specialty Pharmacy provides not only your specialty medicines, but also personalized pharmacy care management services:

- Access to an on-call pharmacist 24 hours a day, seven days a week
- Coordination of care with you and your doctor
- Convenient delivery directly to you or to your doctor's office
- Medicine- and disease-specific education and counseling
- Online support through **www.Caremark.com/specialty**, including disease-specific information and interactive areas to submit questions to pharmacists and nurses

If a covered participant uses medications that are classified by CVS Caremark as specialty medications and wishes to use the prescription drug benefit, the participant should obtain these medications from CVS Caremark Specialty Pharmacy Services. Most of these same drugs also require prior authorization from CVS Caremark, as described below. These drugs are typically only available in up to a 30-day supply, even if taken on a long-term basis.

All specialty medications undergo external review of the program guidelines by clinical experts to ensure the program is unbiased and consistent with current standards of care and practice.

To answer any questions you may have about specialty medications or to find out what medications are considered to be specialty medications for purposes of the Medical Plan, you may contact CVS Caremark Specialty Pharmacy Services directly at 800-237-2767.

SECTION 4 – SPECIAL PROGRAMS

Step Therapy Program

In order to have coverage for prescription medications in certain drug classes, you must try a generic medication first to treat your condition. If you try (or have tried) a generic medication and it does not work for you, then you may receive coverage for a preferred brand medication that your doctor prescribes. If you try (or have tried) a preferred brand medication and it does not work for you, then you may receive coverage for a non-preferred brand medication that your doctor prescribes.

The amount you pay for your prescription will be lowest when you choose a generic medication. If no generic is available – or if it is not right for you – your Medical Plan provides coverage for preferred brand medications, which may also save you money.

However, if you choose to use a preferred brand medication without trying a generic first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the preferred brand medication. If you choose to use a non-preferred brand medication without trying a generic and preferred brand first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the non-preferred brand medication.

For information regarding the drug classes subject to the Step Therapy Program, call CVS Caremark at 888-797-8912.

Maximum Drug Limitation Program

The Medical Plan prescription drug benefits include quantity limits on certain medications, which are applied to address the problem of overuse of medications that can be unsafe for the patient. By following these guidelines, participants are assured of receiving the appropriate safe dosage recommended by the FDA. This means that:

- The Medical Plan will pay only for up to a specified quantity per 30- or 90-day periods.
- In addition, some medications have limitations on the day's supply of medication that may be dispensed to a patient at any one time.
- In certain drug classes, if the medical condition warrants a greater quantity than the established quantity limit, CVS Caremark will discuss the patient's needs with the patient's physician to determine if a greater quantity is medically necessary to treat the condition.

For information regarding the medications subject to the Maximum Drug Limitation Program, call CVS Caremark at 888-797-8912.

Prior Authorization

To ensure that drugs covered by the Medical Plan are used safely and appropriately, certain medications require that physicians obtain prior authorization from CVS Caremark *before* they are covered. Other classes may be added based upon safety, efficiency and FDA approved therapies. Call CVS Caremark at 888-797-8912 to determine if a medication requires prior authorization. Prior authorization does not guarantee coverage or payment under the Medical Plan.

Prior authorization also is required for a preferred brand medication to be covered prior to trying a generic medication, and for a non-preferred brand medication to be covered prior to trying a generic and preferred brand medication, as described above.

In order for medications which require prior authorization to be covered under the Medical Plan, your physician must obtain authorization from CVS Caremark at 800-294-5979 in advance of treatment with these medications.

Drug Utilization Reviews

Drug utilization reviews may help you guard against drug interaction problems that can occur, for example, when medications are prescribed by more than one physician. When your prescriptions are filled through the CVS Caremark Mail Service Pharmacy or at a pharmacy that is participating in the CVS Caremark retail network (using your CVS Caremark prescription ID card), they are reviewed for any potential drug interactions. This review is especially important if you or your covered family members take several medications or see more than one physician. If there is a question about your prescription, a registered pharmacist may contact your physician before dispensing the medication to discuss any alternatives and recommendations. You will be notified of any change in your prescribed medication. Your doctor makes the final decision on all of your prescription medications.

SECTION 5 – COORDINATION OF BENEFITS

Under the prescription drug program, CVS Caremark will not coordinate benefits for prescription drug expenses with other coverage you may have. That is, if you and/or your covered family members have prescription drug coverage under another plan, you may submit your prescription drug claims to whichever plan you choose. For example, if your spouse/domestic partner's medical plan does not cover prescription drugs or requires a higher deductible and coinsurance amount, you may want to use your CVS Caremark prescription ID card, instead of your spouse/domestic partner's plan, to obtain your prescriptions. Alternatively, if your spouse/domestic partner's medical plan requires co-pays to purchase prescription medications in lieu of deductibles and coinsurance, you may want to use your spouse/domestic partner's plan, instead of your CVS Caremark prescription ID card, to obtain your prescriptions.

SECTION 6 – CLAIMS PROCEDURES

How to File a Prescription Drug Program Claim

When you fill your prescription at a pharmacy that is participating in the CVS Caremark retail network and identify yourself as a CVS Caremark participant, you will not have to file a claim form. At the time your prescription is filled, you will have to pay the applicable deductible or coinsurance amount.

If you do not identify yourself to the pharmacist as a CVS Caremark participant, or if you do not use a pharmacy that is participating in the CVS Caremark retail network, you will need to file a claim for reimbursement of your prescription drug expenses through CVS Caremark. When you submit your claim, attach your original receipts and mail your claim to the address shown on the form. An original receipt should show the date of purchase, the name, cost, strength, quantity and days' supply of the medication, the prescription number and the NDC number. When you submit an original receipt, keep a copy for your records. Claim reimbursement is limited to CVS Caremark's discounted price less any required deductible and coinsurance.

CVS Caremark will consider claims for payment, provided your prescription claim is filed within 15 months from the date of service. Claims filed after 15 months from the date of service will not be considered for payment. For example, if you purchase a covered prescription medication on January 15, 2018, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2019 to receive reimbursement for your expenses.

If you are newly eligible, you have a 45-day grace period for prescription drug claims for purchases at full cost in situations where the prescription ID card was not used. The grace period allows participants to be reimbursed at 100%, less the applicable deductible and coinsurance, for paper claims submitted within 45 days from a participant's initial eligibility effective date with CVS Caremark. For example, a participant who's initial effective date with CVS Caremark is January 1, 2018 would have 45 days (until February 14, 2018) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

To obtain a claim form, call CVS Caremark Customer Service at 1-888-797-8912, or go online to **www.Caremark.com**.

Submit claim forms to:
CVS Caremark
P.O. Box 52196
Phoenix, AZ 85072-2196

Reviews & Appeals

The timing for review of your claim depends on the type of claim you submit, as described below. You may designate an authorized representative to assist you with the claims and appeals process described below.

Review Timing for Post-Service Claims

In the case of a post-service claim, CVS Caremark will notify you of the determination within 15 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CVS Caremark's control, it will notify you within 15 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed. The determination period will be suspended on the date CVS Caremark sends such a notice of missing information, and the determination period will resume on the date you respond to the notice. You will have at least 45 days to respond to the request for information.

For these purposes, a post-service claim is any claim that is not a pre-service claim or an urgent care claim, each as defined below.

Review Timing for Pre-Service Claims (Claims Relating to Prior Authorization)

In the case of a pre-service claim, CVS Caremark will inform you of its decision (whether adverse or not) within a reasonable period of time appropriate to the medical condition, but not later than 15 days after it receives the claim. Under special circumstances, CVS Caremark may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which CVS Caremark expects to render a decision.

If additional information is needed because necessary information is missing from the request, the notice will specify what information is needed. You must provide the specified information to CVS Caremark within 45 days after receiving the notice. The determination period will be suspended on the date CVS Caremark sends a notice of missing information and the determination period will resume on the date you respond to the notice.

If you have not followed the proper procedures for filing your pre-service claim, you will be notified of the failure and the proper procedures to be followed in filing pre-service claims. This notice will be provided to you as soon as possible, but not later than 5 days, following the failure. This notification may be oral, unless you request written notification.

For these purposes, a pre-service claim means any claim for a benefit with respect to which the terms of the prescription drug program condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Review Timing for Urgent Care Claims
If your claim is an urgent care claim, CVS Caremark will notify you of its decision on your claim (whether adverse or not) as soon as possible, but no later than 72 hours after it receives the claim. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable, CVS Caremark will inform you as soon as possible, but no later than 24 hours after it receives the claim, of the specific information necessary to complete the claim. You will have a reasonable amount of time, taking into account the circumstances, but no less than 48 hours, to provide the specified information. CVS Caremark will notify you of its determination on your claim as soon as possible, and no later than 48 hours after the earlier of (1) CVS Caremark's receipt of the specified information and (2) the end of the period provided to you to provide the specified additional information.

If you have not followed the proper procedures for filing your urgent care claim, you will be notified of the failure and the proper procedures to be followed in filing urgent care claims. This notice will be provided to you as soon as possible, but not later than 24 hours, following the failure. This notification may be oral, unless you request written notification.

For these purposes, an urgent care claim is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Notice of Adverse Determination
In the event of an adverse benefit determination, in whole or in part, you will be notified of the adverse determination in writing.

An adverse benefit determination is a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Medical Plan benefit. An adverse benefit determination notification for any prescription drug program claim will contain:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the prescription drug program's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your rights to bring a civil action under section 502(a) of ERISA following any final internal adverse benefit determination on appeal and any time limits for filing such a civil action;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;
- a statement that a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim is available free of charge upon request;
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims;

- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If the adverse benefit determination relates to an urgent care claim, the information described above may be provided to you orally within the required time frame, provided that a written or electronic notification is provided no later than 3 days after the oral notification.

When You Have a Complaint or an Appeal
If your claim is denied, you may request a full review by CVS Caremark within 180 days of the date of the adverse benefit determination. Your written letter of appeal should include the following:

- your name and participant ID number;
- your doctor's name and telephone number;
- the name of the medication; and
- any additional information from your pharmacy or medical provider that will assist CVS Caremark in completing its review of your appeal, such as documents, records, questions or comments.

Documents, records, written comments, and other information in support of your appeal should accompany your request. This information will be considered by CVS Caremark in reviewing your claim. You may request reasonable access to copies of all documents, records, and other information relevant to your claim. CVS Caremark will review your claim without granting any deference to the initial decision regarding your claim. Also, no reviewer may be a person that was involved in making the initial decision regarding your claim, or a subordinate to that person. If the claim was based, in whole or in part, on a medical judgment in reviewing the claim, CVS Caremark will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person (or a subordinate of a person) consulted by CVS Caremark in deciding the initial claim. Your appeal should be mailed to:

Caremark, Inc.
Department of Appeals, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

CVS Caremark can also be reached by fax at 866-689-3092. In the case of an appeal relating to an urgent care claim, you may request an expedited appeal orally by contacting CVS Caremark

at 888-797-8912 or in writing. All necessary information will be transmitted by telephone, fax or other available similarly expeditious manner.

To the extent required by applicable law:

- you will be allowed to review your claim file and to present evidence and testimony as part of the internal claims and appeals process;
- CVS Caremark will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the prescription drug program (or at the direction of the prescription drug program) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date; and
- if the denial of your appeal is based on a new or additional rationale, CVS Caremark will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Timing of Appeal Notification for Post-Service Claims
In the case of a post-service claim, CVS Caremark will notify you of its decision on your appeal within 30 days of its receipt of your request for review.

Timing of Appeal Notification for Pre-Service Claims (Claims Requiring Preauthorization)
In the case of a pre-service claim, CVS Caremark will provide notification of its determination on appeal within a reasonable amount of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

Timing of Appeal Notification for Urgent Care Claims
In the case of an urgent care claim, CVS Caremark will provide notification of its determination on appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request for review.

Notice of Benefit Determination on Appeal
Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate the external appeals process;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and your right to bring an action under ERISA section 502(a) following any final internal adverse benefit determination and any applicable time limits for bringing such an action;

- a statement that copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal are available upon request and free of charge;
- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Second Level Appeal Process for Post-Service Claims
If your post-service claim is denied on appeal, you have a right to bring a second appeal within 30 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in "When You Have a Complaint or Appeal" above. CVS Caremark will notify you of its decision on your appeal within 30 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in "Notice of Benefit Determination on Appeal" above, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Second Level Appeal Process for Pre-Service Claims
If your pre-service claim is denied on appeal, you have a right to bring a second appeal within 15 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in "When You Have a Complaint or Appeal" above. CVS Caremark will notify you of its decision on your appeal within 15 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in "Notice of Benefit Determination on Appeal" above, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Voluntary External Review Program
Once you have exhausted the internal claims and appeals process described above, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. External review is available only after internal appeals are exhausted and is available only for certain types of adverse benefit determinations, as defined by federal regulations.

If you wish to file a request for external review, you must submit your request within 4 months of the date of your receipt of CVS Caremark's final internal adverse determination on your

appeal. Contact CVS Caremark at the telephone number shown on your CVS Caremark prescription ID card for more information on how to file a request for external review of your appeal.

CVS Caremark will determine if your appeal is eligible for the voluntary external review program and will provide you with a written notice of its determination. If your request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the request complete, and, in order to pursue an external review, you must provide the required information within the 4-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If your claim is eligible for external review, CVS Caremark will assign your claim to an IRO. The IRO will notify you of the acceptance of your claim for external review, and this notice will include a statement that you may submit to the IRO in writing within 10 business days following receipt of the notice any additional information the IRO should consider in conducting the external review.

The IRO will review all of the information and documents it receives in a timely manner. You will receive written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the prescription drug program;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

If your request for external review relates to an urgent care claim, CVS Caremark will determine if the appeal is eligible for the voluntary external review program and will provide you with written notice of its determination immediately. If the urgent care claim is eligible for external review, CVS Caremark will assign the urgent care claim to an IRO as described above. The IRO will review all of the information and documents relevant to the appeal, to the extent the information and documents are available and the IRO considers them appropriate. The IRO will provide notice to you and the Medical Plan of the final external review decision as soon as possible, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not provided in writing, the IRO will provide you and the Medical Plan with a written confirmation of its decision within 48 hours after the date of providing the notice.

Legal Action
You have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the internal claims and appeals procedure. You may not initiate a legal action until you have completed the first and second level internal appeal processes. No legal action may be brought more than one year following a final decision on the claim under the internal appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority
The authority to decide initial claims for prescription drug program benefits under the prescription drug program and denied claims for prescription drug benefits on review under the prescription drug program includes the full power and discretion to interpret prescription drug program provisions and to make factual determinations, with CVS Caremark's decisions, interpretations and factual determinations controlling, unless overturned through the voluntary external review program described above. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to CVS Caremark at the address listed above. Call CVS Caremark Customer Service for additional information regarding the appeals process.

This is a guide of covered expenses and expenses not covered under the prescription drug program. This guide contains selected highlights of Duke Energy's employee benefits plans. If any statement herein, or any other communication, conflicts with the applicable plan documents, the plan documents will govern. Duke Energy retains the right to amend, modify or terminate its benefits plans in any respect and at any time, and neither its benefits plans, nor your plan participation, will be considered a contract for future employment. For more information about applicable deductibles, coinsurance and plan limits, please call CVS Caremark Customer Service or visit ***www.Caremark.com****. For more detailed information on the Medical Plan, refer to the Duke Energy Active Medical Plan General Information Booklet and UnitedHealthcare® Benefits Booklet sections of this Summary Plan Description.*

The Duke Energy medical plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 888.465.1300. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888.465.1300. 注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：888.465.1300.

UnitedHealthcare® is a registered mark of United Health Group, Inc.

SECTION 7 – PRESCRIPTION DRUG BENEFIT SUMMARY

	CVS Caremark Retail Pharmacy Network For short-term medications (up to a 30-day supply) you pay:	**Maintenance Choice® CVS Caremark Mail Service Pharmacy or CVS Retail Pharmacy** For long-term medications (up to a 90-day supply) you pay:
Preventive Medications Includes certain contraceptive medications and routine vaccines	**$0**	**$0**
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**20%** of medication cost (after your deductible has been met)	**20%** of medication cost (after your deductible has been met)
Preferred Brand Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from the CVS Caremark Primary/Preferred Drug List.	**20%** of medication cost (after your deductible has been met)	**20%** of medication cost (after your deductible has been met)
Non-Preferred Brand Medications You will pay the most for medications not on the CVS Caremark Primary/Preferred Drug List.	**20%** of medication cost (after your deductible has been met)	**20%** of medication cost (after your deductible has been met)
Annual In-Network Deductible The deductible is a combined medical and prescription drug deductible.	$2,500 per year for individual coverage / $5,000* per year for family coverage	
Out-of-Pocket Maximum** The out-of-pocket maximum is a combined medical and prescription drug out-of-pocket maximum.	$5,000 per year for individual coverage / $10,000*** per year for family coverage	

*The deductible is a true family deductible. The full $5,000 amount must be reached before the Medical Plan pays any benefit for any covered member of the family (other than in-network benefits for certain preventive care services and preventive medications, including certain contraceptives and routine vaccines).

**Amounts you pay to satisfy the deductible and amounts you pay as co-insurance are applied toward your out-of-pocket maximum and are included for purposes of determining whether you have reached your out-of-pocket maximum.

***Not to exceed $6,850 for any one individual

Maintenance Choice® is a registered mark of Caremark, LLC.

The Duke Energy medical plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 888.465.1300. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888.465.1300. 注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：888.465.1300.

DUKE ENERGY®

Active Medical Plan

Health Savings Plan 2 option

January 2018

This document replaces any documents previously issued which described your benefits.

Duke Energy Active Medical Plan
General Information

IMPORTANT NOTICE

This General Information booklet for the Duke Energy Active Medical Plan ("Medical Plan") provides information that is applicable to all Medical Plan coverage options. This booklet addresses eligibility for coverage under the Medical Plan, how to enroll, opportunities to make mid-year changes, when coverage ends and how you and your covered dependents may be able to continue coverage if it ends. It also contains information such as who provides coverage, who administers the Medical Plan, who decides claims for benefits, ERISA rights and Duke Energy Corporation's right to amend or terminate the Medical Plan.

The attached Medical Plan booklets and summaries of benefits describe your Medical Plan benefits, applicable deductible, co-pay and co-insurance information, how to submit a claim for Medical Plan benefits and other important information about your Medical Plan.

This General Information booklet, together with the Medical Plan booklets and summaries of benefits, is the Summary Plan Description (SPD) for the Medical Plan as of January 2018 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

TABLE OF CONTENTS

Page

Medical Coverage Availability

Duke Energy Corporation ("Duke Energy") offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (the "Claims Administrators"). The Medical Plan includes medical, surgical, hospitalization, prescription drug, wellness and disease management benefits.

There are various Medical Plan coverage options available, such as high-deductible health plan (HDHP) and preferred provider organization (PPO) options. If you do not have adequate access to network providers, you may qualify for an out-of-area (OOA) option. All of the Medical Plan options are designed to help you pay for health care expenses.

Duke Energy myHR™ Service Center

If you have any questions about the Medical Plan or the information in this General Information booklet, contact the Duke Energy myHR Service Center at 1-888-465-1300. Information also is available through the *Your Benefits Resources*™ (YBR) website at http://resources.hewitt.com/duke-energy.

Eligibility

Eligible Employees

Generally, you are eligible for coverage under the Medical Plan on your first day of active work as an eligible employee (provided you enroll within 31 calendar days of the date you become an eligible employee).

To be an eligible employee, you must be identified in and paid through Duke Energy's payroll system as an employee of Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan (individually or collectively referred to with Duke Energy as the "Company," as appropriate) and you must be classified by your Company as a:

- regular employee: or
- fixed-term employee.

Generally, you are a regular employee if you fill a regular position that is typically longer than 180 days in duration, and you are a fixed-term employee if you are hired for a position for a specifically defined time frame, duration of a project (usually one year or less), until services are no longer needed, or until the work goes away.

You are not eligible to participate in the Medical Plan if you are:

- a non-resident alien with no U.S. source income;
- not on a U.S. payroll of the Company;
- covered by a collective bargaining agreement, unless the collective bargaining agreement in effect expressly provides for participation in the Medical Plan (a copy of your applicable collective bargaining agreement can be obtained from your union steward, union hall, Duke Energy Labor Relations contact or immediate supervisor);

- an individual who has waived eligibility through any means, including an individual whose employment is governed by a written agreement (including an offer letter setting forth terms and conditions of employment) that provides the individual is not eligible for benefits (a general statement in the agreement, offer letter or other communication stating that the individual is not eligible for benefits is construed to mean that the individual is not eligible to participate in the Medical Plan); or
- a temporary employee, a seasonal employee or any other employee who is not a regular employee or fixed-term employee.

In some circumstances, an individual who provides services to the Company under an agreement that identifies the individual as an independent contractor or through a third party (such as a contracting services firm, temporary agency or leasing organization) may be considered a Company "employee" for certain purposes under the law, such as tax withholding. Such an individual is not paid through the Company's payroll system and is not eligible for the Medical Plan.

Eligible Dependents

When you enroll for certain coverage, you may elect to cover your eligible dependents, which may include:

- your eligible spouse
- your eligible domestic partner
- your eligible child(ren)

Spouse Eligibility

Your spouse, eligible for coverage as a dependent, is a person to whom you are legally married under applicable law, which may include "common law marriage" and "same-sex marriage."

Generally, for health coverage of a taxpayer's spouse to be tax-free to the taxpayer, the spouse must be recognized as such under applicable state law and any related federal guidance, which may include "common law marriage" and "same-sex marriage."

By enrolling your spouse in the Medical Plan, you are affirmatively representing that your spouse is eligible for coverage under the Medical Plan. Failure to drop your spouse from coverage constitutes a continuous affirmation of your spouse's eligibility.

You must immediately report any spouse who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your spouse's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible spouse, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your spouse after your spouse ceases to be eligible will be considered a misrepresentation of your spouse's eligibility.

Domestic Partner Eligibility

If you are enrolled in Medical Plan coverage, you can elect coverage for your eligible same- or opposite-sex domestic partner. You and your domestic partner must continuously:

- be each other's sole domestic partner, and intend to remain so indefinitely;
- be at least 18 years of age and mentally competent to enter into a legal contract;
- have lived together in a common household for the immediately preceding 6 consecutive months;
- share financial obligations of, and be jointly responsible for, the common household;
- not be legally married to or legally separated from anyone else, nor in a domestic partnership with anyone else; and
- not be related by blood or marriage to a degree of closeness that would prohibit marriage to one another in your current state of residence.

By enrolling your domestic partner in the Medical Plan, you are affirmatively representing that your domestic partner is eligible for coverage under the Medical Plan. Failure to drop your domestic partner from coverage constitutes a continuous affirmation of your domestic partner's eligibility.

You must immediately report any domestic partner who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your domestic partner's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible domestic partner, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your domestic partner after your domestic partner ceases to be eligible will be considered a misrepresentation of your domestic partner's eligibility.

Child Eligibility

Your child is:

- your biological child, up to age 26; **or**
- your legally adopted child, including a child placed in your home for legal adoption by you as long as the child remains in your home and the adoption procedure has not been terminated, and whether or not the adoption has become final, up to age 26; **or**
- your stepchild, up to age 26; **or**
- your foster child, up to age 26; **or**
- your domestic partner's biological child, legally adopted child (including a child placed in your home for legal adoption by your domestic partner as long as the child remains in your home and the adoption procedure has not been terminated, whether or not the adoption has become final), stepchild or foster child, who is primarily dependent on you for support, whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26; **or**
- any other child for whom you, your spouse or your domestic partner has legal guardianship, full or joint legal custody or managing conservatorship under a valid court decree, who is primarily dependent on you for support, whom you claim as a dependent

for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26.

In addition, your child may be covered at any age if:

- he or she became physically or mentally incapable of self-support while enrolled in a Company-sponsored medical plan and before reaching the applicable limiting age of 26 and continuously remains incapacitated and enrolled in a Company-sponsored medical plan; **or**
- he or she was physically or mentally incapable of self-support on your date of employment with the Company, was enrolled in a Company-sponsored medical plan as of your employment date and continuously remains incapacitated and enrolled in a Company-sponsored medical plan.

By enrolling a dependent child in the Medical Plan, you are affirmatively representing that the child is eligible for coverage under the Medical Plan. Failure to drop your child from coverage constitutes a continuous affirmation of your child's eligibility.

You must immediately report any dependent child who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your dependent child's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible dependent child, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your child after your child ceases to be eligible will be considered a misrepresentation of your child's eligibility.

An eligible child only can be covered by one Company employee or retiree.

Surviving Spouse, Domestic Partner and Child Eligibility

If you die while you and your spouse/domestic partner are covered under the Medical Plan, your surviving spouse/domestic partner may continue Medical Plan coverage by making contribution payment arrangements with the Duke Energy myHR Service Center. This coverage can be continued until the earliest of your spouse's remarriage, your domestic partner's establishment of a new domestic partner relationship, the death of your spouse/domestic partner and the date that your spouse/domestic partner becomes eligible for other coverage (e.g., through an employer's plan or Medicare).

If you are survived by dependent children, their medical coverage may continue for as long as they:

- continue to meet the definition of eligible dependents; and
- make required payments for coverage. Payment arrangements should be coordinated with the Duke Energy myHR Service Center.

This provision applies even if your spouse/domestic partner dies or loses coverage after you.

Your surviving spouse/domestic partner and/or dependent children will be charged for their component of the contribution for coverage. If coverage under the Medical Plan is declined or

ends, your covered dependents may be eligible for continued coverage under COBRA for up to 36 months in certain situations.

Your spouse/domestic partner must immediately report any dependents who should be dropped from survivor coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your dependent's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for ineligible dependents, your spouse/domestic partner should contact the Duke Energy myHR Service Center. Any failure to drop coverage for a dependent after the dependent ceases to be eligible will be considered a misrepresentation of the dependent's eligibility.

See *Termination of Coverage for Non-Payment* for a description of what happens when required payments for coverage are not made.

If you are covered under the Medical Plan and your spouse/domestic partner is an eligible retiree who is covered as your dependent, your spouse/domestic partner may elect retiree coverage under the Duke Energy Retiree Medical Plan or individual coverage through an insurance exchange at the time of your death if your spouse/domestic partner has not reached age 65 at the time of your death, or may be able to elect individual coverage through a Medicare exchange if your spouse/domestic partner is age 65 or older at the time of your death.

Employee and Retiree Couples

No one may be considered as a dependent of more than one employee or more than one retiree.

Verification of Dependent Status

By enrolling your dependent in the Medical Plan, you are affirmatively representing that your dependent is eligible for coverage under the Medical Plan. You will be required to provide evidence of dependent eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order, adoption papers or proof of joint residency within 30 calendar days following the date of enrollment. If you fail to provide proper evidence of dependent eligibility in a timely manner, coverage for your dependent generally will end 45 calendar days following the date of enrollment. See *Claims Determination Procedures* for a description of how to file an eligibility or enrollment claim if your dependent's Medical Plan coverage ends due to a failure to timely provide evidence of dependent eligibility. If your claim or appeal is granted, coverage for your dependent may be reinstated retroactively to the date coverage for your dependent was dropped.

To continue coverage beyond age 26 for a child who is physically or mentally incapable of self-support, you must provide evidence of your child's incapacity to the Medical Plan Claims Administrator. The application can be obtained by contacting the Duke Energy myHR Service Center. You may be required periodically to provide evidence of the child's continuing incapacity.

If a Dependent Becomes Ineligible

If a covered spouse, domestic partner or dependent child becomes ineligible for coverage during the year (for example, if your child reaches age 26), the individual(s) who become(s) ineligible for coverage will be dropped from your coverage.

You must immediately report any dependents who should be dropped from coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. When you report a dependent's loss of eligibility within 31 calendar days of the loss of eligibility:

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage; and

- changes to your contribution amounts will be made as soon as administratively practicable after the date on which you notify the Duke Energy myHR Service Center that your dependent is no longer eligible.

If you do not inform the Duke Energy myHR Service Center of a covered dependent's ineligibility within 31 calendar days of the loss of eligibility:

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage;

- no changes to your coverage level, if applicable, may be made until the next annual enrollment period or, if earlier, the date you experience another work/life event which allows you to change your Medical Plan election (this means that you must continue to pay for the dependent's coverage through the end of the year in which the dependent loses eligibility for coverage even though he or she is no longer covered, unless you experience another work/life event which allows you to change your Medical Plan election);

- the coverage provided while your dependent is ineligible will be considered as part of the individual's COBRA coverage period (this period begins on the first day of the month following the month in which eligibility is lost); and

- COBRA contributions (102% of the total cost) will be required to pay for the coverage received since the end of the month in which eligibility was lost if the individual elects continuation of coverage under COBRA.

To drop coverage for ineligible dependents, contact the Duke Energy myHR Service Center.

The Company reserves the right to seek recovery of any benefits paid under the Medical Plan to your ineligible dependents.

Enrolling in the Medical Plan

When You Are First Eligible

When you are eligible to enroll, you will make your Medical Plan election using an online enrollment tool. You will receive additional information about the online enrollment tool when you become eligible.

If you have questions or need assistance in making your Medical Plan election, contact the Duke Energy myHR Service Center.

When you enroll in the Medical Plan as an eligible employee, based on the dependent(s) that you elect to cover, if any, your coverage level will be one of the following:

- Individual Only
- Individual + Spouse/Domestic Partner
- Individual + Child(ren)
- Individual + Family (Spouse/Domestic Partner and Child(ren))

You must make your election within 31 calendar days of becoming eligible for coverage in order for coverage to begin on the date you become an eligible employee. If you do not make your election within 31 calendar days of becoming eligible, your next opportunity to enroll will be during a subsequent annual enrollment period or within 31 calendar days of a work/life event for which mid-year changes are allowed.

By accessing the enrollment tool or calling the Duke Energy myHR Service Center and making your coverage election when you are first eligible, you are affirmatively representing that all information provided during enrollment including, but not limited to, the eligibility of any dependents for coverage and/or your non-tobacco user status (and that of your spouse/domestic partner, as applicable) is true and correct. If Duke Energy discovers that any information you provide during enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

You also may decline coverage altogether.

During Annual Enrollment

Each fall you will have the opportunity to change your Medical Plan election for the following plan year, including changing your coverage option or electing to drop or add eligible dependents. This process is referred to as "annual enrollment." You will receive information and instructions each fall about annual enrollment.

By accessing the enrollment tool or calling the Duke Energy myHR Service Center and making (or not changing, as applicable) your coverage election during annual enrollment, you are affirmatively representing that all information provided during annual enrollment including, but not limited to, the eligibility of any dependents for coverage, your completion of any wellness program initiatives and/or your non-tobacco user status (and that of your spouse/domestic partner, as applicable) is true and correct. If Duke Energy discovers that any information you provide during annual enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

Other Opportunities to Enroll

Under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you can enroll yourself and your eligible dependents for coverage under the Medical Plan during the year if:

- you or your dependent had other coverage under another health plan or health insurance at the time the Medical Plan was previously offered to you; and
- you did not enroll in the Medical Plan; and
- you or your dependents lose such other coverage and are otherwise eligible for coverage under the Medical Plan.

To enroll for Medical Plan coverage in such a circumstance, the following conditions must be satisfied:

- The other coverage was:
  - Under a federal continuation provision (COBRA) and the continuation period for the other coverage was exhausted. (COBRA coverage is considered exhausted when it ceases for any reason other than either failure of the individuals to pay contributions on a timely basis or for cause (fraudulent or intentional misrepresentation).)
  - Not under COBRA and the other coverage terminated as a result of (1) loss of eligibility (such as loss of eligibility due to legal separation, divorce, death, termination of employment or reduction in the number of hours of employment), or (2) employer contributions toward the other coverage end.

In any case, the other coverage must not have terminated because you failed to pay timely contributions, or for cause (such as filing fraudulent claims).

HIPAA also allows you to enroll yourself, your eligible spouse and/or your newly eligible child if you acquire an eligible dependent through marriage, birth, adoption or placement for adoption.

If you need to enroll for coverage under the Medical Plan as a result of one of these events (such as loss of other coverage, or because you acquire an eligible dependent through marriage, birth, adoption or placement for adoption) you must enroll within 31 calendar days of the event. Otherwise, unless a subsequent work/life event giving rise to a mid-year change occurs (see *Mid-Year Changes*), you must wait until the next annual enrollment.

HIPAA also allows you to enroll yourself and your eligible dependents for coverage under the Medical Plan during the year if:

- you or your eligible dependents lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you or your eligible dependents, as applicable, are no longer eligible; or
- you or your eligible dependents become eligible for premium assistance under a Medical Plan option through a state's premium assistance program under Medicaid or CHIP.

If you need to enroll for coverage under the Medical Plan as a result of one of these two events, you must enroll within 60 calendar days of the event. Otherwise, unless a subsequent work/life event giving rise to a mid-year change occurs (see *Mid-Year Changes),* you must wait until the next annual enrollment.

If You Are Rehired

If your Medical Plan coverage ends due to your termination of employment with the Company or layoff and you are reemployed by the Company as an active employee within 31 calendar days

and within the same plan year, you will be automatically reenrolled in the Medical Plan (in the previous coverage option and at the previous coverage level). If you have experienced a work/life event for which you can make a change in your Medical Plan election (such as marriage, divorce or birth), you can add and/or drop coverage for your eligible dependent(s), as applicable, within 31 calendar days of the date you again become an eligible employee. If you are reemployed more than 31 calendar days after your termination or in a subsequent plan year, you must reenroll as a new employee.

If you retire from the Company as an eligible retiree and are later rehired as an eligible active employee, you will be eligible for coverage as an active employee. When your employment subsequently terminates, you may be able to reelect retiree coverage under the Duke Energy Retiree Medical Plan or individual coverage through an insurance exchange if you are not yet age 65 at that time, or you may be able to elect individual coverage through a Medicare exchange if you are age 65 or older at that time.

Cost of Coverage

You and the Company share in the cost of medical coverage for yourself and your covered dependents. Your contribution amount is based on the Medical Plan coverage option that you elect and the eligible dependent(s) you choose to cover. Information about contribution amounts is available through the YBR website.

Your contributions for medical coverage while an employee are deducted from your pay on a pre-tax basis each pay period. Because your contributions are taken as deductions on a pre-tax basis, they are not subject to federal income, Social Security and most states' income taxes.

Even though you reduce your income for tax purposes through pre-tax contributions for medical coverage, you are not reducing the value of your other Company pay-related benefits, such as life insurance, disability insurance and retirement benefits. These benefits are based on your pay before contributions for medical coverage are deducted.

If you elect coverage for a domestic partner, the portion of your contribution required to cover the domestic partner under the Medical Plan is deducted on a pre-tax basis. On pay advice statements, the value of the coverage associated with the benefits you elected under the Medical Plan for your domestic partner will appear as imputed income and is subject to applicable taxes. Please note that the Company does not provide tax advice, and you should consult with your tax advisor for information about the tax consequences of electing coverage for a domestic partner.

Live Well Incentive Program

Under the Duke Energy *Live Well* Incentive Program (the "*Live Well* Program"), you and your spouse/domestic partner may be eligible to earn rewards that will be applied to reduce your contributions for coverage under the Medical Plan during the following calendar year. For example, if you complete a Biometric Screening under the *Live Well* Program during an applicable year's program cycle, or if your spouse/domestic partner completes a Health Survey under the *Live Well* Program during an applicable year's program cycle, the rewards you and your spouse/domestic partner earn for completing these activities may be applied to reduce your contributions for medical coverage each pay period throughout the following year on a pro-rated basis (i.e., applied evenly to reduce the contribution you make toward the cost of medical coverage each payroll period during the following year).

Employee Eligibility

You are eligible to earn rewards under the *Live Well* Program if you are a U.S.-based active employee who is eligible for the Medical Plan or if you are a U.S.-based employee on an approved paid leave of absence who is eligible for the Medical Plan, whether or not you are enrolled in the Medical Plan. However, you are not eligible to earn rewards under the *Live Well* Program if you are approved for an unpaid leave of absence or long-term disability benefits under a Duke Energy-sponsored long-term disability plan.

Any rewards you earn under the *Live Well* Program will generally be applied to reduce your contributions for coverage under the Medical Plan during the following calendar year. However, if you do not enroll in the Medical Plan for a calendar year, or you are an employee who will be covered under the Medical Plan in a calendar year as a dependent of another Company employee, your *Live Well* Program rewards earned during an applicable year's program cycle will be paid in cash (less applicable taxes) on a prorated basis in your paycheck each pay period during the following calendar year.

There are instances in which you may not receive the *Live Well* Program rewards you have earned, as described below.

- If you are not enrolled in the Medical Plan while you are on an unpaid leave of absence or receiving long-term disability benefits under a Duke Energy-sponsored long-term disability plan, you will not receive any rewards that you earned during the prior year's program cycle that have not been redeemed when your leave of absence or long-term disability benefits commence. You will receive the rewards that you earned during the prior year's program cycle only if you return to active employment during the calendar year following the year in which you earned your rewards, in which case your remaining rewards will be paid to you in cash (less applicable taxes) on a prorated basis in your paycheck during the remaining pay periods in that calendar year.

- If you terminate your employment during a calendar year, you will not receive the rewards that you earned during the prior year's program cycle that have not been redeemed as of your termination date.

- You will not receive the rewards that you earned during the prior year's program cycle that have not been redeemed as of the date you cease to be eligible for the Medical Plan.

Spouse/Domestic Partner Eligibility

Your spouse/domestic partner is eligible to participate in the *Live Well* Program only if you are eligible to participate in the *Live Well* Program as described above, and your spouse/domestic partner is actually enrolled in the Medical Plan. If you are not eligible to participate in the *Live Well* Program, your spouse/domestic partner is not eligible to participate in the *Live Well* Program either, even if your spouse/domestic partner is actually enrolled in the Medical Plan.

If your spouse/domestic partner does not enroll in the Medical Plan for a calendar year, neither you nor your spouse/domestic partner will receive *Live Well* Program rewards your spouse/domestic partner earned during the preceding year's program cycle. This means that your spouse's/domestic partner's *Live Well* Program rewards earned during the preceding year's program cycle will not be used to reduce your contributions for medical coverage throughout the calendar year and will not be paid to you or your spouse/domestic partner in cash.

Live Well Program Activities and Rewards

The activities that you and/or your spouse/domestic partner must complete to receive *Live Well* Program rewards may vary with each program cycle. Review the *Live Well* Program materials sent to you prior to the beginning of each calendar year for additional information on the upcoming program cycle's activities and requirements.

The Medical Plan is committed to helping you achieve your best health. Rewards for participating in the *Live Well* Program are available to all employees who are eligible to participate in the Medical Plan, regardless of Medical Plan enrollment. If you think you might be unable to complete an activity required for you to receive a reward under the *Live Well* Program, you might qualify for an opportunity to earn the same reward by different means. Contact Health and Wellness Portal Support at 1-877-818-5826 and a representative will work with you (and, if you wish, your doctor) to find an activity with the same reward that is right for you in light of your health status.

Non-Tobacco User Discount

A non-tobacco user discount also is available to reduce the cost of coverage under the Medical Plan coverage options. To qualify for the applicable non-tobacco user discount, you (and your spouse/domestic partner) must:

- be tobacco free (including smokeless tobacco and electronic cigarettes);
- have been tobacco-free (including smokeless tobacco and electronic cigarettes) during the 12 months preceding the effective date of your coverage (or during such other period as may be communicated to you in your annual enrollment materials); and
- remain tobacco free (including smokeless tobacco and electronic cigarettes) during the coverage period.

In order to receive the non-tobacco user discount for you and/or your spouse/domestic partner you must complete:

- a non-tobacco user attestation ("Attestation") when you enroll in the Medical Plan using the online enrollment tool or through the Duke Energy myHR Service Center, and
- if you attest to being a tobacco user, the Alternate Procedure Certification described below by the specified deadline.[1]

If you do not complete the Attestation during enrollment, or, if you complete the Attestation and attest to being a tobacco user but you do not complete the Alternate Procedure Certification described below by the applicable deadline, you (and your spouse/domestic partner) will not receive the non-tobacco user discount for Medical Plan coverage. Tobacco user status does not carry over from year to year for Medical Plan coverage.

[1]We will work with you (and/or your spouse/domestic partner) and, if you wish, with your doctor and/or your spouse's/domestic partner's doctor, prior to the Alternate Procedure Certification submission deadline, to find an alternate procedure that provides the same non-tobacco user discount that is right for you (and/or your spouse/domestic partner) in light of your (and/or your spouse's/domestic partner's) health status.

By completing the Attestation in the online enrollment tool or through the Duke Energy myHR Service Center, you are affirmatively representing your (and your spouse's/domestic partner's) tobacco user status and if you (and your spouse/domestic partner) are tobacco-free, your eligibility for the non-tobacco user discount under the Medical Plan. If you complete the Attestation as a non-tobacco user during enrollment and you (or your spouse/domestic partner) become a tobacco user during the period of coverage, you must notify the Duke Energy myHR Service Center within 31 calendar days of the date that you (or your spouse/domestic partner) become a tobacco user. Changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice.

If you misrepresent your tobacco user status (or the tobacco user status of your spouse/domestic partner) in the Attestation, or if you (or your spouse/domestic partner) become a tobacco user after completing the Attestation as a non-tobacco user and you do not notify the Duke Energy myHR Service Center of the change in tobacco user status, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

Non-Tobacco User Discount – Alternate Procedure for Active Employees

The Medical Plan is committed to helping you (and your spouse/domestic partner) achieve your best health. The non-tobacco user discount is available to all covered employees (and their covered spouses/domestic partners). If you (and/or your covered spouse/domestic partner) do not qualify for the non-tobacco user discount because you are not currently tobacco free, have not been tobacco free for the 12 months preceding the effective date of your coverage (or during such other period as may be communicated to you in your annual enrollment materials) or intend to use tobacco during the coverage period, you may still qualify for the discount if you satisfy one of the following requirements.

- If you are enrolling as a newly eligible employee (and/or a newly eligible spouse/domestic partner), you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - enroll in the Quit for Life Tobacco Cessation Program (the "Quit for Life Program") within 31 days of the date you enroll in your benefits, and
    - properly complete and submit a written Alternate Procedure Certification within 31 days of the date you (and/or your spouse/domestic partner) enroll in your benefits certifying that you (and/or your spouse/domestic partner) have enrolled in the Quit for Life Program and that you (and/or your spouse/domestic partner) will complete the Quit for Life Program within seven months of enrolling in the Quit for Life Program[2] – or –

[2] If you (and/or your covered spouse/domestic partner) enrolled in the Quit for Life Program and you properly completed and submitted the Alternate Procedure Certification within 31 days of the date you (and/or your spouse/domestic partner) enrolled in your benefits, but you (and/or your spouse/domestic partner) have not yet reached your seven month completion deadline for the Quit for Life Program by annual enrollment, you may qualify for the non-tobacco user discount if you properly complete and submit a written Alternate Procedure Certification during annual enrollment on or before the communicated deadline stating that you (and/or your spouse/domestic partner) enrolled in the Quit for Life Program on or before the communicated deadline and that you (and/or your spouse/domestic partner) will complete the

- If you are enrolling during annual enrollment, you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - enroll in the Quit for Life Program on or before the communicated deadline, and
    - properly complete and submit an Alternate Procedure Certification on or before the communicated deadline certifying that you (and/or your spouse/domestic partner) enrolled in the Quit for Life Program on or before the communicated deadline and that you (and/or your spouse/domestic partner) will complete the Quit for Life Program on or before the following June 30.

The Alternate Procedure Certification is found on the Duke Energy Portal. You may contact the Duke Energy myHR Service Center to discuss remitting the information required under the alternate procedure. You will not receive the non-tobacco user discount until your Alternate Procedure Certification has been approved, at which time the non-tobacco user discount will be applied on a prospective basis as soon as administratively practicable.

To enroll in the Quit for Life Program, contact Quit for Life at 1-866-784-8454. You (and/or your spouse/domestic partner) will not be required to pay for the cost of the Quit for Life Program. Please note that the Quit for Life Program takes up to six months to complete. You can begin the Quit for Life Program as soon as you enroll. After your (and/or your spouse's/domestic partner's) initial year of claiming the discount in accordance with this procedure, in order to continue the non-tobacco user discount under the alternate procedure in any future year, a new Alternate Procedure Certification will be required.

If You Do Not Successfully Complete the Alternate Procedure

Duke Energy will audit your (and/or your spouse's/domestic partner's) completion of the Alternate Procedure (including completion of the Quit for Life Program). If you (or your spouse/domestic partner) certify that you will complete the Quit for Life Program and you (and/or your spouse/domestic partner) do not complete the Quit for Life Program by the deadline indicated in the alternate procedure, you must notify the Duke Energy myHR Service Center within 31 calendar days of the date that you (or your spouse/domestic partner) fail to meet the deadline. Changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice or, if earlier, the date that the Company learns of such failure.

If You Misrepresent Information in the Alternate Procedure Certification

If you misrepresent any information in your Alternate Procedure Certification, including, but not limited to, your enrollment in the Quit for Life Program, or if you do not complete the Quit for Life Program by the applicable deadline, Duke Energy reserves the right to recover any contribution amounts you should have paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of health and insurance coverage and/or discharge, and to take other appropriate action.

Quit for Life Program by the original completion date of seven months after your initial enrollment in the Quit for Life Program.

Termination of Coverage for Non-Payment

Your coverage will be terminated for non-payment if:

- you do not make the required payment in full for two months; or
- you call the Duke Energy myHR Service Center to indicate the payment is being sent, but it does not arrive by the due date.

If your coverage is terminated for non-payment, you will receive a Confirmation of Coverage statement indicating that your coverage has been cancelled.

Except in cases of termination of COBRA coverage for non-payment, reinstatement after non-payment is possible if you contact the Duke Energy myHR Service Center no later than three months from the date printed on the Confirmation of Coverage statement. However, past due contributions must be paid in full to reinstate coverage. Reinstatement after non-payment will be allowed only one time. If COBRA coverage is terminated for non-payment, reinstatement is not available. Any amounts owed in arrears at the time of a death or coverage change will continue to be billed and must be paid.

When Coverage and Contributions Begin

When you make your Medical Plan election as a newly eligible employee, coverage begins on the date you become eligible (assuming that you make your election within 31 calendar days of becoming eligible). Deductions for your contributions begin as soon as administratively practicable following the date that you make your election.

When you make your coverage elections during annual enrollment, coverage begins on January 1 of the following calendar year. Deductions for your contributions begin the first pay period of the following calendar year.

Mid-Year Changes

Once you have made your Medical Plan election for the year, you may not change it during that year unless you have a work or life event for which a mid-year election change is permitted and the work or life event results in the gain or loss of eligibility for coverage. Specific information about these "work/life" events and allowable mid-year election changes is available through the YBR website located on the Duke Energy Portal or by contacting the Duke Energy myHR Service Center. A "mid-year election change" refers to any change made to your coverage during a calendar year due to a work or life event that results in the gain or loss of eligibility for coverage.

If you experience a work/life event for which mid-year election changes are allowed, you have 31 calendar days from the date of the event (for example, your marriage date) to change your election. Otherwise, unless a subsequent work/life event giving rise to a mid-year election change occurs, you cannot change your Medical Plan election until annual enrollment.

If you are eligible to make changes, the election you make must be consistent with and on account of the work/life event.

Below is a list of some work/life events for which mid-year election changes are allowed:

- Your legal marital status changes
  - you get married
  - you get divorced or have your marriage annulled
  - you get legally separated and lose coverage under your spouse's employer plan
  - your spouse dies
- Your domestic partner status changes
  - your domestic partner becomes eligible for coverage
  - your domestic partner relationship ends
  - your domestic partner dies
- The number of your eligible children changes
  - you have, or adopt, a child
  - you become the legal guardian of a child
  - your child gains or loses eligibility for coverage under the Medical Plan (for example, your dependent child reaches age 26)
  - a Qualified Medical Child Support Order (QMCSO) is received[3]
  - your child dies
- Your dependent's benefits coverage changes because:
  - he or she gains or loses coverage due to a change in eligibility as a result of a change in employment status or work schedule
  - his or her period of coverage and annual enrollment window is different from yours
- Your or your dependent's COBRA coverage from another employer expires
- You enroll in a qualified health plan through a federal or state Marketplace during the Marketplace's annual enrollment period or during a special enrollment period available in the Marketplace
- You or your dependent becomes entitled to or loses Medicare or Medicaid[4]
- You or your dependent loses or gains coverage under a group health plan
- There is a significant increase or decrease in the cost of coverage under the employer plan in which your dependent participates
- You die

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[3] If a Qualified Medical Child Support Order is issued requiring medical coverage for your child, you may change your medical coverage election to provide coverage for your child. You also may make an election change to cancel medical coverage for the child if the order requires the child's other parent to provide coverage.

[4] Entitlement to Medicare or Medicaid. If you, your spouse or any dependent child is enrolled in the Medical Plan and subsequently become entitled to coverage in Part A or Part B of Medicare or in Medicaid, you may make an election to cancel Medical Plan coverage for that individual.

When Your Dependent Is No Longer Eligible

If a covered dependent ceases to be eligible for benefits, your dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage. If you notify the Duke Energy myHR Service Center within 31 calendar days of the loss of eligibility, changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice. See *If a Dependent Becomes Ineligible* for information about the consequences of failing to notify the Duke Energy myHR Service Center within 31 calendar days of a loss of eligibility.

When You Enroll a Dependent Mid-Year

If your change is to add a dependent to your Medical Plan coverage, and your dependent's eligibility for Medical Plan coverage has not previously been verified, you will be required to provide evidence of dependent eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order, adoption papers or proof of joint residency within 30 calendar days following the date of enrollment. If you fail to provide proper evidence of dependent eligibility in a timely manner, coverage for your dependent generally will end 45 calendar days following the date of enrollment. See *Claims Determination Procedures* for a description of how to file an eligibility or enrollment claim if your dependent's Medical Plan coverage ends due to a failure to timely provide evidence of dependent eligibility. If your claim or appeal is granted, coverage for your dependent may be reinstated retroactively to the date coverage for your dependent was dropped.

When Mid-Year Coverage and Contribution Changes Are Effective

This section outlines the timing of coverage and contribution changes when you (i) elect to start or increase coverage due to a work/life event, (ii) elect to decrease or terminate coverage due to a work/life event or (iii) stop or decrease coverage due to a covered individual becoming ineligible for coverage (e.g., divorce or child reaches age 26).

- **Start or Increase Coverage**. If you elect to start or increase your coverage due to a work/life event, your coverage changes on the day the work/life event occurred. In order for the change to take effect on the day the work/life event occurred, you must notify the Duke Energy myHR Service Center within 31 calendar days of the work/life event. Changes to your contribution amounts are effective as soon as administratively practicable after you submit your election changes.

- **Elective Decrease or Termination of Coverage**. If you elect to decrease or terminate coverage due to a work/life event, your coverage changes on the first day of the month after you submit your election changes. You must notify the Duke Energy myHR Service Center within 31 calendar days of the work/life event in order for the change to become effective on the first day of the month after you submit your election changes. Changes to your contribution amounts are effective as soon as administratively practicable after you submit your election changes.

- **Decrease or Termination of Coverage Due to Loss of Eligibility**. Coverage for individuals who are no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage. Changes to your contribution amounts generally are effective as soon as administratively practicable after you submit your

election changes provided that you notify the Duke Energy myHR Service Center within 31 days of the loss of eligibility. See *If a Dependent Becomes Ineligible* above for the consequences of failing to notify the Duke Energy myHR Service Center of a covered individual's ineligibility within 31 calendar days of the loss of eligibility. Note that in the event of your death, coverage for you and your dependents ends on the date of your death. See *Surviving Spouse, Domestic Partner and Child Eligibility* above for information about coverage available to your spouse/domestic partner and/or child if you die while they are covered under the Medical Plan.

Situations Impacting Your Eligibility for Coverage

If You Are on an Authorized Leave of Absence

While you are on an authorized leave of absence, you may be eligible to continue your coverage under the Medical Plan. Contact the Duke Energy myHR Service Center for additional information regarding your ability to continue coverage under the Medical Plan during an authorized leave of absence. If your authorized leave of absence is unpaid such that you begin to be billed directly for the monthly contribution for your medical coverage, see *Termination of Coverage for Non-Payment* for a description of what happens when required payments for coverage are not made.

If You Become Disabled

If you begin receiving disability benefits under the Duke Energy Short Term Disability Plan or the Duke Energy Long Term Disability Plan, you may be eligible for continued coverage under the Medical Plan. Contact the Duke Energy myHR Service Center for additional information regarding your ability to continue coverage under the Medical Plan if you begin receiving disability benefits. If you begin to be billed directly for the monthly contribution for your medical coverage, see *Termination of Coverage for Non-Payment* for a description of what happens when required payments for coverage are not made.

When You Reach Age 65

If you continue to work past age 65, Medical Plan coverage for you and your covered dependents will continue as long as you remain an eligible employee, your covered dependents remain eligible dependents and you pay any required contributions. If you continue to work past age 65, your Medical Plan coverage will be primary to Medicare for you and any covered dependents over age 65, except in certain situations related to an end stage renal disease diagnosis.

If You Become Entitled to Medicare

If you are "not actively at work" and you become entitled to Medicare, you can elect to continue your coverage under the Medical Plan or enroll in individual coverage through a Medicare exchange. If you wish to continue your enrollment in Duke Energy-sponsored coverage, you will be required to enroll in a Medical Plan option that coordinates with Medicare Part B (note that there is no coordination of benefits between the Medical Plan's prescription drug coverage and Medicare Part D). For these purposes, you are considered to be "not actively at work" if you are not actively working as an employee or you have been receiving long-term disability benefits for six months or longer. Contact the Duke Energy myHR Service Center for additional information regarding the options available to you when you become entitled to Medicare.

If you elect to terminate your coverage under the Medical Plan when you become entitled to Medicare, any of your eligible dependents who are covered under the Medical Plan and are not eligible for Medicare may continue coverage under the Medical Plan until reaching age 65.

If you are "not actively at work" because you have been receiving long-term disability benefits for six months or longer and you and/or a covered dependent enroll in a Medicare prescription drug plan for a calendar year, you and/or your covered dependent will not be eligible for coverage under the Medical Plan for that calendar year. Therefore, Medical Plan coverage ends for a calendar year for individuals who enroll in a Medicare prescription drug plan mid-year. Such individuals may be able to enroll for Medical Plan coverage at the next annual enrollment if Medicare prescription drug coverage is dropped for the following calendar year.

Termination of Coverage

When Coverage Ends

Your coverage under the Medical Plan will cease on the earliest of the following dates:

- the last day of the month in which your employment ends, unless you elect to continue coverage under COBRA;
- the last day of the month in which you cease to be an eligible employee or dependent or otherwise cease to be eligible for coverage under the Medical Plan;
- the last day of the month in which a work stoppage begins;
- the end of the period for which your last required contribution was made;
- the date of your death; or
- the date the Medical Plan is discontinued.

Your dependent's coverage will end when your coverage ends, at the end of the period for which your last required contribution was made, on the last day of the month in which you elect not to cover the dependent, or on the last day of the month in which the dependent loses eligibility, unless he or she continues his or her coverage under COBRA or through survivor coverage, as applicable. Medical Plan coverage actually will terminate, but it will be reinstated retroactive to the coverage termination date if the COBRA enrollment is properly received and processed. COBRA enrollment forms must be completed and received within 60 days of the event or notification, whichever is later.

If You Become Divorced or Your Domestic Partner Relationship Ends

If you cover a spouse/domestic partner under the Medical Plan and you become divorced or your domestic partner relationship ends, you must drop coverage for your former spouse/domestic partner within 31 calendar days of the divorce or the date on which your domestic partner relationship ends. Your former spouse/domestic partner will then be notified that he or she may continue coverage through COBRA by contacting the COBRA administrator within 60 days of the qualifying event.

See *If a Dependent Becomes Ineligible* for a description of what happens when you either do or do not report your divorce or the end of your domestic partner relationship within 31 calendar days.

To drop coverage for your former spouse/domestic partner, contact the Duke Energy myHR Service Center.

If You Leave the Company

If your employment with the Company terminates, your coverage under the Medical Plan will end on the last day of the month in which your employment terminates, unless you elect to continue coverage under COBRA.

See *If You Are Rehired* for a description of what happens if you are reemployed by the Company after your termination of employment.

If You Retire

If you are an eligible retiree, you may elect retiree coverage under the Duke Energy Retiree Medical Plan or individual coverage through an insurance exchange if you have not reached age 65 when you retire, or individual coverage through a Medicare exchange if you are age 65 or older when you retire. Additional information about your coverage options will be provided to you when you retire.

COBRA Continuation Coverage

Under COBRA (Consolidated Omnibus Budget Reconciliation Act), you, your spouse and eligible dependent children may elect to continue Medical Plan coverage if certain qualifying events occur. Although domestic partners are not entitled to continuation coverage under COBRA, the Company will apply the same rules to a domestic partner as to a spouse.

There also may be other coverage options available to you and your family if you experience a qualifying event. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace.

Continued Coverage for You

You may continue coverage for yourself and your covered eligible dependents under the Medical Plan for up to 18 months if you lose coverage under the Medical Plan due to:

- termination of your employment (for reasons other than gross misconduct); or
- a reduction of your work hours.

Continued Coverage for Your Dependents

Your covered dependents may continue their coverage under the Medical Plan for up to 36 months if they lose coverage as a result of your:

- death;
- divorce;
- termination of domestic partner status; or
- dependent child ceasing to be a dependent as defined by the Medical Plan.

Newborn and Adopted Children

If you give birth or adopt a child while you are on COBRA continuation coverage, you may enroll your new child for COBRA coverage within 31 calendar days following the date of the birth or adoption. Your newborn or adopted child will be a "qualified beneficiary." This means that your child will have independent election rights and multiple qualifying event rights. (Refer to *Multiple Qualifying Events*.)

In Case of Disability

You and your covered dependents may be eligible for up to 29 months of continued coverage if you or your dependents receive a determination from the Social Security Administration stating that you or your dependents were disabled at the time you elected COBRA coverage or at any time during the first 60 days of COBRA coverage, provided the disability lasts at least until the end of the 18-month period of continuation coverage.

You must notify the Duke Energy myHR Service Center of any Social Security Administration disability determination in writing within the initial 18-month coverage period and within 60 days of the determination. Your verbal notice is not binding until confirmed in writing and the Duke Energy myHR Service Center receives a copy of the Social Security disability determination. You also must notify the Duke Energy myHR Service Center within 30 days of the date you are determined by the Social Security Administration to no longer be disabled.

If You Become Covered by Medicare

If you become entitled to Medicare while you are an active employee and you later experience a qualifying event (e.g., a termination of employment), you and your dependents may be eligible for continued coverage when the qualifying event occurs. If COBRA is elected, coverage for your covered dependents will extend 36 months from the date you first became covered by Medicare or the maximum coverage period for the qualifying event (18 months in the case of termination of employment or reduction in hours) whichever is later.

For example, suppose you are actively employed on January 1, 2018, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2019, your eligible dependents would be eligible for continued coverage until the later of:

- 36 months following the date you become covered for Medicare – January 1, 2021; or

- 18 months following your termination of employment – July 1, 2020

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2021 if COBRA continuation coverage is elected.

Multiple Qualifying Events

If your dependents experience more than one qualifying event while COBRA coverage is active, they may be eligible for an additional period of continued coverage not to exceed 36 months from the date of the first qualifying event.

For example, if you terminate employment, you and your dependents may be eligible for 18 months of continued coverage. During this 18-month period, if your dependent child ceases to be a dependent under the Medical Plan (a second qualifying event), your child may be eligible for an additional period of continued coverage. This period would not exceed a total of 36 months from the date of the loss of your coverage due to your termination (the first qualifying event).

Procedures to Obtain Continued Coverage

Both you and the Company have responsibilities if qualifying events occur that make you or your covered dependents eligible for continued coverage.

You or your covered dependents must notify the Duke Energy myHR Service Center within 60 days when one of these qualifying events occurs:

- you become divorced;
- your domestic partner relationship ends;
- your dependent child is no longer considered an eligible dependent as defined by the Medical Plan; or
- you or an eligible dependent is determined to be disabled by the Social Security Administration.

If these procedures are not followed, or if notice is not provided to the Duke Energy myHR Service Center during the 60-day notice period, then your covered dependents will lose their rights to elect COBRA coverage.

For other qualifying events, such as your death, termination of employment or reduction in work hours, it is the Company's responsibility to notify the COBRA administrator.

Election Period

The Company's COBRA administrator will notify you or your covered dependents of your right to elect continued coverage. Each qualified beneficiary has independent election rights and has 60 days to elect coverage, beginning on the later of:

- the date coverage terminates by reason of the qualifying event, or
- the date notification of the right to elect continued coverage is mailed to you and your covered dependents.

Type of Coverage

If you choose continued coverage, you will initially have the same medical coverage you had on the day before your qualifying event. During your COBRA continuation period, any changes to the medical coverage of similarly situated active employees also will apply to your medical coverage as a COBRA qualified beneficiary. In addition, if your COBRA continuation period extends into a future plan year, you will be able to change your Medical Plan COBRA election for the following plan year during annual enrollment to the same extent that similarly situated active employees are able to change their Medical Plan elections for the following plan year during annual enrollment.

Cost

You and your covered dependents will be required to pay 102% of the full group cost for your continued coverage. The 2% is intended to cover administrative fees. The contributions are paid on an after-tax basis.

You will be asked to pay for coverage in monthly installments. Your first payment will be retroactive to the date of your qualifying event and will be due no later than 45 days after the date you elected continued coverage. Coverage will be effective once the initial premium is paid. Once payment is received, notification of coverage will be passed on to the applicable Claims Administrator. You may refile claims that may have been denied between your benefits termination and your election to continue coverage. You will be required to make monthly payments thereafter, with a 30-day grace period. If the cost or benefits change in the future for active employees, the changes also will affect continued coverage under COBRA. You will be notified of any changes in the cost or benefits associated with your coverage.

Termination of Continued Coverage

COBRA coverage automatically ends if any of the following occurs:

- the COBRA participant fails to make the required contribution on time;
- the Company terminates the Medical Plan for all employees; or
- the COBRA participant becomes covered under another group medical plan (as an employee or otherwise) after the election of COBRA coverage.

Conversion Privilege

The Medical Plan has no conversion privilege. This means that you are not able to convert your coverage under the Medical Plan to an individual policy upon your termination from the Company or when coverage ends.

Qualified Medical Child Support Orders (QMCSOs)

If the Company receives notification that, as a result of a QMCSO, you are required to provide Medical Plan coverage for a dependent child, the Company will:

- notify you (and any other person named in the order) of receipt of the order; and

- within a reasonable period of time (up to 30 days), determine if the child is eligible for coverage under the Medical Plan and notify you in writing of the decision.

As appropriate to the court order, the child will be enrolled for medical coverage, unless there are legal proceedings that dispute the determination. If the court order is disputed, claims processing will be delayed until the dispute is resolved.

If the child's covered expenses are paid by a custodial parent or legal guardian who is not a participant in the Medical Plan, reimbursement of these expenses will be made directly to the custodial parent or legal guardian if required by the order. Custodial parents and legal guardians also may sign claim forms and assign benefits to providers. The Claims Administrator will send notification of payment of providers to the custodial parent.

If you do not comply with the procedures required by the order, the Company may change your coverage status to that required by the court order and deduct the appropriate contributions from your pay at the direction of the court.

Your Role

As a participant in the Medical Plan, please follow the guidelines below.

- File accurate claims. If someone else (other than the provider) files a claim on your behalf, you must review the form before you sign it.
- Review the explanation of benefits when it is returned to you. Make sure that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered.
- Never allow another person to seek medical treatment under your identity.
- Provide complete and accurate information on claim forms and any other forms; answer all questions to the best of your knowledge.

You must notify the applicable Claims Administrator if a provider:

- bills you for services or treatment that you have never received;
- asks you to sign a blank claim form; or
- asks you to undergo tests that you feel are not needed.

Any covered person who knowingly intends to defraud the Medical Plan will be considered guilty of fraud. If you are concerned about any of the charges that appear on a bill or explanation of benefits form or if you know of or suspect any illegal activity, call the applicable Claims Administrator at the toll-free number on your I.D. card. All calls are strictly confidential.

Other Important Information

Plan Sponsor

Duke Energy Corporation is the sole sponsor of the Medical Plan. The Company address, telephone number and employer identification number (EIN) are:

Duke Energy Corporation
550 South Tryon Street
Charlotte, NC 28202
980-373-8649
EIN: 20-2777218

Identification Numbers

If you need to correspond with the federal government about the Medical Plan, you should include in the correspondence the Duke Energy Corporation EIN and the plan number assigned to the Medical Plan. The Medical Plan is a component plan under the Duke Energy Active Health & Welfare Benefit (Financed) Plans, plan number 502.

Funding

Benefits under the Medical Plan generally are provided from funds held by trustees. All Medical Plan claims are paid from the Duke Energy Corporation Welfare Benefits Trust VEBA I with Bank of New York Mellon as trustee. The address for Bank of New York Mellon is:

Bank of New York Mellon
BNY Mellon Center
500 Grant Street
Pittsburgh, PA 15258

The Company also may provide benefits under the Medical Plan from its general assets.

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy Benefits Committee (the "Benefits Committee"). The Benefits Committee has responsibility and authority to control and manage the operation and administration of the Medical Plan, except to the extent delegated or assigned to others.

The Benefits Committee may assign or delegate any of its authority or duties to others. The Benefits Committee has appointed Duke Energy Human Resources to serve as the Initial Claim Administrator and the Duke Energy Claims Committee (the "Claims Committee") to serve as Denied Claim Reviewer for claims as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or any coverage option under the Medical Plan. The Benefits Committee, the Claims Committee and Duke Energy Human Resources may be contacted as follows:

Benefits Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

Claims Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

Duke Energy Human Resources
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

The Benefits Committee has appointed the Claims Administrators to serve as Initial Claim Administrators and Denied Claim Reviewers for claims for benefits under the Medical Plan. The Claims Administrators may be contacted at the addresses listed in the Medical Plan booklets. You also can obtain additional information by contacting the Duke Energy myHR Service Center.

The Benefits Committee, the Claims Committee, Duke Energy Human Resources and the Claims Administrators, and/or any delegate thereof, each within its area of authority and responsibility, have power and discretion to construe and interpret the Medical Plan and to make factual determinations.

Investment Committee

The named fiduciary for the maintenance and investment of the plan assets that are held in the Duke Energy Corporation Welfare Benefits Trust VEBA I is the Duke Energy Investment Committee. The Board of Directors of Duke Energy Corporation appointed the Chairman of the Investment Committee, who in turn appoints the other members of the Investment Committee. Any successor Chairman of the Investment Committee is appointed by the Finance and Risk Management Committee of the Board of Directors of Duke Energy Corporation.

The Investment Committee may be contacted through the following address:

Investment Committee
Director, Long Term Investments
Duke Energy Corporation
550 South Tryon Street, DEC40A
Charlotte, NC 28202

Plan Year

The plan year for the Medical Plan is January 1 through December 31.

Service of Legal Process

The person designated for service of legal process upon the Medical Plan is:

Corporate Secretary
Duke Energy Corporation
550 South Tryon Street

Charlotte, North Carolina 28202

Legal process also may be served upon the Medical Plan's trustee, if applicable, or upon the Benefits Committee as Plan Administrator.

Affiliated Employers of Duke Energy That Have Adopted the Medical Plan

Contact the Duke Energy myHR Service Center for information regarding affiliated employers of Duke Energy that have adopted the Medical Plan.

Claim Determination Procedures

There are two different types of claims that may be made under the Medical Plan...Claims for Medical Plan Benefits and Eligibility or Enrollment Claims.

A Claim for Medical Plan Benefits is a claim for Medical Plan benefits made in accordance with the Medical Plan's procedures for filing benefit claims.

An Eligibility or Enrollment Claim is a claim as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or applicable Medical Plan option made in accordance with the Medical Plan's procedures for filing eligibility or enrollment claims. An Eligibility or Enrollment Claim does not include (i) requests to change your Medical Plan coverage level and/or coverage option due to your failure to take action during the applicable enrollment period, (ii) requests to change your Medical Plan coverage level and/or coverage option based solely on a change in your preferred coverage level and/or coverage option, (iii) disputes regarding the cost of your Medical Plan coverage and/or requests to change your Medical Plan coverage level and/or coverage option due to disputes regarding the cost of your Medical Plan coverage, (iv) requests for reinstatement of Medical Plan coverage if your coverage is terminated for non-payment and you have already exhausted your one-time reinstatement opportunity, (v) requests to change your tobacco user status, which includes requests to complete the Alternate Procedure Certification after the communicated deadline or (vi) requests for the Company to record/count wellness activities completed after the communicated deadline.

Claims for Medical Plan Benefits

The Claims Administrators for your Medical Plan options have the authority to decide initial Claims for Medical Plan Benefits, as the Initial Claim Administrators, and denied Claims for Medical Plan Benefits on review, as the Denied Claim Reviewers. The Company has no discretionary authority with respect to Claims for Medical Plan Benefits.

Claims submission procedures for your Medical Plan benefits are described in the Medical Plan booklets for the Medical Plan options in which you participate. You also can obtain additional information by calling the Duke Energy myHR Service Center. To file a valid Claim for Medical Plan Benefits, you (or your authorized representative) must follow the claim submission procedures for the Medical Plan as described in the Medical Plan booklets applicable to the Medical Plan options in which you participate and any updating materials.

Eligibility or Enrollment Claims

The Benefits Committee has appointed Duke Energy Human Resources to decide Eligibility or Enrollment Claims as the Initial Claim Administrator. Duke Energy Human Resources has delegated its authority to decide Eligibility or Enrollment Claims to Alight Solutions Claims and Appeals Management.

The Benefits Committee has appointed the Claims Committee to perform the fair and impartial review of denied Eligibility or Enrollment Claims on appeal as the Denied Claim Reviewer. The Company has no discretionary authority with respect to the Claims Committee's final determinations regarding Eligibility or Enrollment Claims on appeal.

To file a valid Eligibility or Enrollment Claim, you (or your authorized representative) must follow the claim submission procedures for the Medical Plan as described in this General Information booklet and any updating materials.

Initial Claim

If you have an Eligibility or Enrollment Claim, you (or your authorized representative) must submit a claim initiation form. This form can be obtained by calling the Duke Energy myHR Service Center.

The claim form must be submitted in writing to the address on the form and include:

- a statement that the claim is a "Claim for Eligibility/Enrollment" and identification of the Medical Plan;
- your name, Social Security number, mailing address and daytime telephone number;
- a complete description of the claim, including the eligibility/enrollment issue presented;
- dependent information, if applicable; and
- any additional information you want considered.

A "Claim for Eligibility/Enrollment" must be received by Claims and Appeals Management within 12 months after the date on which you are claiming eligibility/enrollment should have occurred. If your claim is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Claims and Appeals Management will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Claims and Appeals Management's control, it will notify you or your representative within 30 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice also will specify what information is needed. The determination period will be suspended on the date Claims and Appeals Management sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice. You will have at least 45 days to respond to the request for information.

Adverse Determination

In the event of an adverse eligibility or enrollment determination, in whole or in part, you (or your authorized representative) will be notified of the adverse determination in writing.

An adverse determination notification for an Eligibility or Enrollment Claim will contain:

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why such information or material is needed;
- an explanation of the claims review process and the time limits applicable to such process, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review and any time limits for filing such a civil action;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request;
- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances; and
- only to the extent required under applicable federal regulations:
    - information sufficient to identify the claim involved;
    - notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
    - a description of the Medical Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and
    - contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

In addition, any such denial notification will be provided in a culturally and linguistically appropriate manner to the extent required by the Patient Protection and Affordable Care Act and any applicable implementing regulations or other federal agency guidance issued thereunder.

Appeal of Adverse Determination

If you disagree with an adverse eligibility or enrollment determination, you (or your authorized representative) can request a review of the initial determination by submitting a written request to the Claims Committee within 180 calendar days after receipt of the adverse determination. If

your appeal is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

A request to the Claims Committee must be submitted in writing to:

Claims Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202

You may request to examine and receive copies of all documents, records and other information relevant to the claim. The Claims Committee will review the appeal without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person that was involved in making the initial decision regarding the claim, or a subordinate to that person. In addition, if the claim was based in whole or in part on a medical judgment, the Claims Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This person will not be a person (or a subordinate of a person) consulted by Claims and Appeals Management in deciding the initial claim. When reviewing an adverse determination that has been appealed, any new information that you provide that was not available or utilized when the initial determination was made will be considered.

You will be allowed to review the claim file and to provide evidence and testimony as part of the internal claims and appeals process. The Claims Committee will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Medical Plan (or at the direction of the Medical Plan) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, if the denial of your appeal is based on a new or additional rationale, the Claims Committee will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. You will be notified regarding the decision on your appeal within 60 days after receipt of the appeal.

The determination of your appeal will be in writing and, if adverse, will contain:

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- a statement about your right to bring a civil action under Section 502(a) of ERISA and any time limits for filing such a civil action;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request;

- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances;
- the following statement: 'You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency'; and
- only to the extent required under applicable federal regulations:
    - information sufficient to identify the claim involved;
    - notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
    - a description of the Medical Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and
    - contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

In addition, any such denial notification will be provided in a culturally and linguistically appropriate manner to the extent required by the Patient Protection and Affordable Care Act and any applicable implementing regulations or other federal agency guidance issued thereunder. Also, upon request, the Claims Committee will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

For additional information on filing an Eligibility or Enrollment Claim or filing an appeal of an adverse determination, you should contact the Claims Committee.

Voluntary External Review Program

Once you have exhausted the internal claims and appeals process, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. External review is available only after internal appeals are exhausted and only for certain types of adverse benefit determinations, as defined by federal regulations.

If your claim is eligible for external review under applicable federal regulations and you wish to file a request for external review, you must submit your request within four months of the date of your receipt of the Claims Committee's final internal adverse determination on your appeal. If your request for external review is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it. Contact the Claims Committee for more information on how to file a request for external review of your appeal.

The Claims Committee will determine if your appeal is eligible for the voluntary external review program and will provide you with a written notice of its determination. If your request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the

request complete, and, in order to pursue an external review, you must provide the required information within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later. If you fail to provide the required information by the applicable deadline, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

If your claim is eligible for external review, the Claims Committee will assign your claim to an IRO. The IRO will notify you of the acceptance of your claim for external review, and this notice will include a statement that you may submit to the IRO in writing within 10 business days following receipt of the notice any additional information the IRO should consider in conducting the external review.

The IRO will review all of the information and documents it receives in a timely manner as outlined in federal regulations and other applicable guidance. You will receive written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to you or the Medical Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

The external review program is completely voluntary, so you only have to exhaust your internal claim and appeal administrative review rights under the Medical Plan in order to bring a civil action against the Medical Plan. Contact the Claims Committee for more information about the Medical Plan's external review procedures.

Legal Action

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the internal claim and appeal procedure. You may not initiate a legal action against the Claims Administrators, the Medical Plan, the Company, or the Plan Administrator until you have completed the internal appeal processes. No legal action may be brought more than one year following a final decision on the claim under the appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority

Authority to decide initial claims (including claims for Medical Plan benefits) under the Medical Plan and denied claims on review (including denied claims for Medical Plan benefits on review) under the Medical Plan includes the full power and discretion to interpret Medical Plan provisions and to make factual determinations, with the Initial Claim Administrators' and the Denied Claim Reviewers' decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to the particular entity identified as having the authority to decide the initial claim, or to decide the denied claim on review, as applicable.

Right to Change or Terminate the Medical Plan

Duke Energy Corporation reserves the right to amend or terminate the Medical Plan in any respect and at any time. For example, the Medical Plan may be discontinued in part or in its entirety, or what the Medical Plan or Medical Plan option covers or what benefits it provides may be changed. Cost sharing between the Company and covered individuals also is subject to change, which may include initiating or increasing contributions required of employees, retirees, other former employees and their dependents.

The amendment or termination of the Medical Plan may affect the benefits or benefit coverage not only of active employees (and their dependents), but also of former active employees who retired (and their dependents), became disabled, died or whose Company employment has otherwise terminated (and their dependents), and also of any covered person who began receiving benefit coverage or payments prior to the amendment or termination. If such a termination or amendment occurs, affected participants will be notified. The right to amend or terminate the Medical Plan may be exercised by Duke Energy Corporation, or its authorized delegates, and any amendment shall be in writing.

In the event of a complete termination of the Medical Plan, eligible claims for Medical Plan benefits will be paid by the Duke Energy Corporation Welfare Benefits Trust VEBA I to the extent that funds are available.

Statement of Rights

As a participant in the Medical Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Medical Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Medical Plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Medical Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Medical Plan, including collective bargaining agreements, and a copy of the latest

annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- receive a summary of the Medical Plan's annual financial report. The Plan Administrator is required by law to furnish each participant in the Medical Plan with a copy of this summary financial report.
- obtain a copy of the Medical Plan's procedures for determining a Qualified Medical Child Support Order (QMCSO).

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse[5] or dependents if there is a loss of coverage under the Medical Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this General Information Booklet and the other documents governing the Medical Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Medical Plan documents or the latest annual report from the Medical Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court once you have exhausted the Medical Plan's internal claims procedures.

In addition, if you disagree with the Medical Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Medical Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If

[5] Additionally, the Company extends continuation of coverage under COBRA to covered domestic partners if they lose eligibility for coverage in certain situations.

you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

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

Keep Us Informed

It is your responsibility to make sure that your benefits records are correct and that the personal information needed to administer your benefits is current. Promptly review any confirmation and other benefit statements carefully, and immediately advise the Duke Energy myHR Service Center if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child is no longer an eligible dependent, contact the Duke Energy myHR Service Center as soon as possible.

A Final Note

Although this General Information Booklet and the other documents that comprise the SPD describe the principal features of the Medical Plan that are generally applicable, the SPD is only a summary. The complete provisions of the Medical Plan are set forth in the plan documents, which are available upon request from Duke Energy Human Resources. An SPD is an overview and is written to be read in its entirety. Descriptions of Medical Plan features should not be taken out of context. Inquiries about specific situations should be directed in writing to Duke Energy Human Resources. Changes to the Medical Plan, pending revision of the SPD, will be communicated in benefit newsletters, letters, Duke Energy Portal announcements and/or enrollment materials. In the event of a conflict between this SPD or any other communication regarding the Medical Plan and the plan documents themselves, the plan documents control. Remember, the Medical Plan may not be amended by oral or written communications.

The Medical Plan, this SPD and your Medical Plan participation are not employment contracts, and do not give any employee the right to continue to be employed by the Company. Employees may resign and are subject to discipline, discharge or layoff as if the SPD had never been published and the Medical Plan had never gone into effect.

The Medical Plan complies with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 888.465.1300. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888.465.1300. 注意：如果您說中文 (Chinese), 我們免費為您提供語言協助服務。請致電：888.465.1300.

Benefit Booklet

Duke Energy Active Medical Plan
Health Savings Plan 2 Option

Effective: January 1, 2018
Group Number: 729784

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorders Administrator: (877) 214-2930.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740809, Atlanta, GA 30374-0800.
- Online assistance: **www.myuhc.com**.

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy Active Medical Plan's Health Savings Plan 2 Option. It includes summaries of:

- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions and Limitations;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Duke Energy is solely responsible for paying Benefits described in this Benefit Booklet.

IMPORTANT
The healthcare service, supply or pharmaceutical product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 12, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Please read this Benefit Booklet thoroughly to learn how the Duke Energy Active Medical Plan's Health Savings Plan 2 Option works. If you have questions call the number on the back of your ID card.

How To Use This Benefit Booklet

- Read the entire Benefit Booklet (including the benefit booklet describing the prescription drug benefit), as well as the General Information Booklet and share them with your family. Together, the General Information Booklet and the Benefit Booklets comprise the Summary Plan Description (SPD) for the Plan's Health Savings Plan 2 Option. Keep these documents in a safe place for future reference.
- Many of the sections of this Benefit Booklet are related to other sections. You may not have all the information you need by reading just one section.
- You can find or request printed copies of your SPD at **http://resources.hewitt.com/duke-energy** or by contacting the Duke Energy myHR™ Service Center at (888) 465-1300.
- Capitalized words in the Benefit Booklet have special meanings and are defined in Section 12, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 12, *Glossary*.
- Duke Energy and its affiliated companies which are participating in the Plan are also referred to as the Company.

SECTION 2 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits;
- Eligible Expenses;
- Annual Deductible;
- Coinsurance; and
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Designated Network Benefits, Network Benefits or Non-Network Benefits.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 4, *Plan Highlights*. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer

to the definition of Shared Savings Program in Section 12, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of the Company or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The Network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

The Plan Administrator has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits. For Designated Network Benefits and Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare determines the Plan will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the Benefit Booklet.

For Designated Network Benefits and Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:

- For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

- For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a master's level counselor.

- When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.

- When a rate is not published by *CMS* for the service, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits (other than Benefits for Network preventive care services). The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to almost all Covered Health Services under the Plan, including Covered Health Services provided through the prescription drug program for Network Benefits only. The only Covered Health Services under the Plan to which the Annual Deductible does not apply are Network preventive care services and certain preventive medications and vaccines which are covered at 100% by the Plan even before you meet your Annual Deductible.

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

If more than one person in a family is covered under the Plan's Health Savings Plan 2 Option, the individual coverage Deductible stated in Section 4, *Plan Highlights* does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits (other than Benefits for Network preventive care services and certain preventive medications and vaccines) until the family Deductible is satisfied.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the applicable annual maximum, the Plan pays 100% of additional Eligible Expenses you incur for Covered Health Services through the end of the calendar year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided through the prescription drug component of the Plan administered by CVS Caremark for Network Benefits only.

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

The following table identifies what does and does not apply toward your applicable Network and non-Network Out-of-Pocket Maximum:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

Amounts that do not apply toward your Out-of-Pocket Maximum are always your responsibility to pay, even after you reach your Out-of-Pocket Maximum.

SECTION 3 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services which Require Prior Authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this Benefit Booklet, the Personal Health Support program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share

important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Prior Authorization

The Plan requires prior authorization for certain Covered Health Services. In general, your Network Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. For detailed information on the Covered Health Services that require prior authorization, please refer to Section 5, *Additional Coverage Details.*

It is recommended that you confirm with the Claims Administrator that prior authorization has been obtained for all Covered Health Services listed below as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services for which they fail to obtain prior authorization as required. You can contact the Claims Administrator by calling the number on the back of your ID card.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.
The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Network providers are generally responsible for obtaining prior authorization from the Claims Administrator or contacting Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from the Claims Administrator prior to receiving a service.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator as shown in Section 5, *Additional Coverage Details* before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if you do not obtain prior authorization from the Claims Administrator, as shown in Section 5, *Additional Coverage Details.*

The services that require prior authorization are:

- Ambulance - non-emergent air;
- Clinical Trials;
- Congenital heart disease surgery;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including breast pumps and diabetes equipment for the management and treatment of diabetes;
- Gender Dysphoria treatment as described under *Gender Dysphoria* in Section 5, *Additional Coverage Details*;
- Genetic testing - Breast Cancer Susceptibility Gene (BRCA);
- Home health care for nutritional foods and skilled nursing;
- Hospice care – inpatient;
- Hospital Inpatient Stay - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery;
- Lab, X-Ray and Diagnostics - Outpatient - sleep studies;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); Intensive Outpatient Program treatment; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management);
- Neurobiological Disorders - Autism Spectrum Disorder Services-inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment facility); Intensive Outpatient Program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*;
- Private Duty Nursing – outpatient;
- Prosthetic devices;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;

- Substance -Related and Addictive Disorders Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication-assisted treatment programs for substance-related and addictive disorders;
- Surgery - sleep apnea surgeries;
- Therapeutic treatments as described in Section 5, *Additional Coverage Details* under *Therapeutic Treatments - Outpatient*;
- Transplants.

For notification timeframes and any reductions in Benefits that apply if you do not obtain prior authorization or notify Personal Health Support, see Section 5, *Additional Coverage Details.*

Notification to Personal Health Support is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

(Applicable only to Medicare enrollees who have Plan coverage under COBRA or due to the receipt of long-term disability benefits under a Company-sponsored long-term disability plan).

If you are enrolled in Medicare on a primary basis, and Medicare pays benefits before the Plan, you are not required to obtain prior authorization before receiving Covered Health Services. Since Medicare pays Benefits first, the Plan will pay Benefits second as described in Section 9, *Coordination of Benefits (COB).*

SECTION 4 - PLAN HIGHLIGHTS

The table below provides an overview of the Plan's Annual Deductible, Out-of-Pocket Maximum and Lifetime Maximum Benefit.

Plan Features	Network	Non-Network
Annual Deductible[1]		
■ Individual	$1,500	$3,000
■ Family (cumulative Annual Deductible[2])	$3,000	$6,000
Annual Out-of-Pocket Maximum[1]		
■ Individual (enrolled in single coverage)	$3,500	$7,000
■ Individual (enrolled in family coverage)	$6,850	$14,000
■ Family (not to exceed the applicable Individual amount per Covered Person)	$7,000	$14,000
Lifetime Maximum Benefit[3] There is no dollar limit on the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

[1]Amounts you pay out-of-pocket that are counted toward the Annual Deductible also apply toward the Out-of-Pocket Maximum.

[2]If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in the table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits (other than Benefits for Network preventive care services and certain preventive medications and vaccines) until the family Deductible is satisfied.

[3] Generally the following are considered to be essential Benefits under the Patient Protection and Affordable Care Act:

Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details.*

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Acupuncture Services Acupuncture services will be reviewed after 20 visits for medical necessity	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ambulance Services		
■ Emergency Ambulance	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
■ Non-Emergency Ambulance	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Cancer Resource Services (CRS)[2] ■ Hospital Inpatient Stay See *Cancer Resource Services (CRS)* in Section 5, *Additional Coverage Details.*	80% after you meet the Annual Deductible	Not Covered
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a Network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each applicable Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Congenital Heart Disease (CHD) Surgery Services[2]	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services -Treatment of a Medical Condition	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Treatment Covered under Plan	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each applicable Covered Health Service category in this section.	
Diabetes Self-Management Items ■ Diabetes equipment (insulin pumps and pump supplies only). See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Emergency Health Services – Outpatient	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Foot Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in your CVS Caremark Prescription Drug Benefit Booklet	
Home Health Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Kidney Resource Services (KRS)[2] (These Benefits are for Covered Health Services provided through KRS only)	80% after you meet the Annual Deductible	Not Covered
Lab, X-Ray and Diagnostics - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services ■ Inpatient. ■ Outpatient.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Nutritional Counseling Up to 6 visits per condition per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Obesity Surgery[2] (The Plan pays Benefits only for Covered Health Services provided through BRS)	80% after you meet the Annual Deductible	Not Covered
Orthotic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	
Preventive Care Services		
■ Physician Office Services.	100%	60% after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Tests.	100%	60% after you meet the Annual Deductible
■ Breast Pumps.	100%	60% after you meet the Annual Deductible
■ Colonoscopy	1 at 100% every 10 years	60% after you meet the Annual Deductible
Private Duty Nursing - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment ■ Cardiac & Pulmonary Rehabilitation Services ■ All other services See *Rehabilitation Services-Outpatient Therapy* in Section 5, *Additional Coverage Details*, for limits.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 150 days per Covered Person per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Spine and Joint Surgeries MANDATORY In order to receive Spine and Joint Surgeries Benefits at a Designated Provider you must contact a Spine and Joint Solution (SJS) Nurse and enroll in the SJS Program prior to surgery. An SJS Nurse may be reached by calling 1-877-214-2930.	80% after you meet the Annual Deductible when you use a Designated Provider	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	**Non-Network**
Substance-Related and Addictive Disorders Services ■ Inpatient. ■ Outpatient.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services Any combination of Network and Non-Network Benefits for oral appliances and associated expenses are limited to a $1,500 maximum per Covered Person per lifetime.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible Note: Non-Network dialysis is not covered under the Plan.
Transplantation Services Non-Network Benefits include services provided at a Network facility that is not a Designated Provider and services provided at a non-Network facility.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Travel and Lodging (If services rendered by a Designated Provider)	For patient and companion(s) of patient undergoing transplant, obesity surgery, Spine and Joint Surgery services, cancer treatment or Congenital Heart Disease treatment	
Urgent Care Center Services	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible	Not Covered
Vision Examinations	*Routine Vision Examination:* 100% *Non-Routine Vision and refraction eye examination:* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Wigs Up to a $500 maximum per Covered Person per lifetime	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]You must obtain prior authorization from the Claims Administrator, as described in Section 3, *Personal Health Support and Prior Authorization* to receive full Benefits for certain Covered Health Services. See Section 5, *Additional Coverage Details* for further information. In general, if you visit a Network provider, that provider is responsible for obtaining prior authorization from the Claims Administrator before you receive certain Covered Health Services. See Section 5 *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through BRS, CRS, CHD and KRS at a Designated Provider. For oncology services not provided through CRS or for congenital heart disease surgery services not provided through CHD, or for kidney services not provided through KRS the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient*, and *Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.* The Plan does not pay any Benefits for obesity surgery not provided through the BRS program.

SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call to obtain prior authorization.

This section supplements the second table in Section 4, *Plan Highlights.*

While the table in Section 4, *Plan Highlights* provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 7, *Exclusions and Limitations.*

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Acupuncture services will be reviewed after 20 visits for medical necessity.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal- directed services or if goals have previously been met.

Did you know...
You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 12, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services, please remember that you must obtain prior authorization from the Claims Administrator as soon as possible prior to the transport. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 12, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or a Personal Health Support Nurse.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.

- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Provider.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Clinical Trials

The Plan pays for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as determined by UnitedHealthcare, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.

- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*

- Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgery Services

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD surgery services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the number on your ID card for information about these guidelines.

The Plan pays Benefits for Congenital Heart Disease (CHD) surgery services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD surgery services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by UnitedHealthcare to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you should contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD surgery services received at a Congenital Heart Disease Resource Services program.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises.

If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Dental Services - Accident Only

Accident only dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within 3 months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for accidental Injury for children. Timing of when the Covered Services will be rendered is determined by the Physician.

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Dental Services – Treatment of a Medical Condition

The Plan covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental treatment required as a result of a medical condition, but which is not an integral component of the treatment of that condition, is not covered (examples include decayed teeth due to dry mouth from medication or disease, or treatment of disease).

Dental Treatment Covered under Plan

The Plan provides Benefits for services provided by a duly licensed doctor, doctor of dental surgery or doctor of dental medicine for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, when the procedure is related to one of the following conditions:

- Congenital deformity, including cleft lip and cleft palate; and

- Removal of:
  - Tumors;
  - cysts which are not related to teeth or associated by dental procedures; and
  - exostoses for reasons other than preparation of dentures.

The Plan provides Benefits for dental implants and related procedures, such as bone grafting associated with the above three conditions.

In addition, Benefits may be provided for dentures and orthodontic braces if used to treat congenital deformity including cleft lip and cleft palate.

When any of the conditions listed above require surgical correction, Benefits for surgery will be subject to a Covered Health Service review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth.

In special cases, Benefits are only provided for anesthesia and facility charges related to dental procedures performed in a hospital or ambulatory surgical center. This Benefit is only available to dependent children below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating provider must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other dental services, including the charge for surgery, are not covered unless specifically covered by the Plan.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	■ Insulin pumps and pump supplies for the management and treatment of diabetes based upon the medical needs of the Covered Person. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Diabetic supplies such as monitors, syringes, test strips, and lancets are covered under the Plan's prescription drug benefit.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen;
- Equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- Delivery pumps for tube feedings;
- Breast pumps (only as provided under the Health Resources and Services Administration (HRSA) requirement);
- Negative pressure wound therapy pumps (wound vacuums);
- Burn garments;
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital – Inpatient Stay, Rehabilitation Services – Outpatient Therapy* and *Surgery – Outpatient* in this section;
- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part, cranial orthotics (helmets)for correction of positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, shoes/inserts made from a mold of a Covered Person's foot; Charges for custom built orthopedic shoes when medically necessary must be prescribed by a doctor and limited to two (2) pairs per calendar year;
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage;
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every five calendar years.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the five year timeline for replacement.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 2, *How the Plan Works*.

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within 48 hours of the admission or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Foot Care

The Plan covers hygienic and preventive maintenance foot care; cutting or removal of corns and calluses, nail trimming, cutting, or debriding only if the treatment is a Covered Health Service and related to a medical condition.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- **Psychotherapy** for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Services* in this section.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in this section.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided under the Plan's prescription drug benefit.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

  - Clitoroplasty (creation of clitoris).
  - Labiaplasty (creation of labia).
  - Orchiectomy (removal of testicles).
  - Penectomy (removal of penis).
  - Urethroplasty (reconstruction of female urethra).
  - Vaginoplasty (creation of vagina).

  Female to Male:

  - Bilateral mastectomy or breast reduction.
  - Hysterectomy (removal of uterus).
  - Metoidioplasty (creation of penis, using clitoris).
  - Penile prosthesis.
  - Phalloplasty (creation of penis).
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries).
  - Scrotoplasty (creation of scrotum).
  - Testicular prosthesis.
  - Urethroplasty (reconstruction of male urethra).
  - Vaginectomy (removal of vagina).
  - Vulvectomy (removal of vulva).

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category in this section.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

- Not considered Custodial Care, as defined in Section 12, *Glossary.*
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 12, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization for nutritional foods and skilled nursing, from the Claims Administrator five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-

based Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) services provided by Designated Providers participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 12, *Glossary.*

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Personal Health Support.
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.

- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography, including 3D mammograms (breast tomosynthesis) for screening or diagnosis of breast cancer.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.* Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirement
For Non-Network Benefits for sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement
For Non-Network Benefits for sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

- Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management, you must obtain prior authorization for Non-Network Benefits before services are received.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits you must obtain prior authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout (a form of arthritis).
- Renal failure.
- Phenylketonuria (a genetic disorder diagnosed at infancy).
- Hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to six individual sessions per calendar year for each medical condition.

Obesity Surgery

(The Plan pays Benefits only for Covered Health Services provided through BRS)

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician if any of the following are true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea, hypertension, cardiopulmonary condition or diabetes) directly related to, or exacerbated by, obesity.

In addition to meeting the above criteria the following must also be true:

- you have any life threatening or serious medical condition that is weight induced;
- a psychological examination of the Covered Person's readiness and fitness for surgery and the necessary postoperative lifestyle changes has been completed;
- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years;
- you have completed a 6-month Physician supervised weight loss program; and
- you have completed a pre-surgical psychological evaluation.

Coverage of surgical treatment of morbid obesity is limited to adults who are 18 years old or older.

You will have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program, as defined in Section 12, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling the toll-free number on the back of your ID card.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with obesity-related services received at a Designated Provider.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 12, *Glossary* and are not Experimental or Investigational or Unproven Services.

Please remember Non-Network Benefits for obesity surgery are not available.

Orthotic Devices

Refer to the Durable Medical Equipment (DME) section above for details.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-Ray and Diagnostics - Outpatient.*

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA. If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Please Note
Your Physician does not have a copy of your Benefit Booklet, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

If you fail to obtain prior authorization as required, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 6, *Clinical Programs and Services*, for details.

Preventive Care Services

The Plan pays Benefits for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

Examples of preventive care services include routine physical examinations, well-baby and well-child care, immunizations, screening mammograms and prostate screenings. Preventive care Benefits for women defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting or purchasing one breast pump per Pregnancy in conjunction with childbirth.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

Preventive care Benefits for women defined under the Health Resources and Services Administration (HRSA) requirement also include the following:

- Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes;
- Human papillomavirus testing in women with normal cytology results beginning at age 30 and no more frequently than once every three years;
- Annual counseling for sexually transmitted infections;
- Annual counseling and screening for human immune-deficiency virus;
- Comprehensive lactation support and counseling in conjunction with each birth, by a trained provider during pregnancy and/or in the postpartum period;
- All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, as prescribed by a doctor; and
- Annual screening and counseling for interpersonal and domestic violence.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining a breast pump that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), as defined in Section 12, *Glossary*.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator for Private Duty Nursing – Outpatient visits. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every five calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are more than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry without regard to the lapse of time between the mastectomy and the reconstructive surgery. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 12, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedure is performed.
- A non-scheduled Reconstructive Procedure, you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy;
- Occupational therapy;
- Manipulative/Chiropractic Treatment;
- Speech therapy;
- Post-cochlear implant aural therapy;
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- Pulmonary rehabilitation; and
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- The services are ordered by a Physician and provided and administered by a licensed provider.
- The services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- The services require clinical training in order to be delivered safely and effectively.
- The services are not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. Rehabilitation services will be reviewed after 40 visits for medical necessity. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Also, other than as described under Habilitative Services above, Physical therapy, Occupational therapy and Post-cochlear implant aural therapy will be reviewed after 40 visits for medical necessity.

Manipulative/Chiropractic Treatment will be reviewed after 20 visits for medical necessity.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient.* Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services.*

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12, *Glossary.*

Any combination of Network Benefits and Non-Network Benefits is limited to 150 days per Covered Person per calendar year.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency), you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Spine and Joint Solution (SJS) Program MANDATORY

The Spine and Joint Solution (SJS) program is for eligible participants age 18 and older. SJS provides support before, during, and after surgery. Nurses help direct participants to high-quality facilities and provide them case management support.

In scope procedures include:

- Spine Fusion Inpatient Surgery.
- Disc Inpatient Surgery.
- Total Hip Replacement Inpatient Surgery.
- Total Knee Replacement Inpatient Surgery.

If care involves a hospital admission, it may also require that surgery is performed at an SJS Center of Excellence (COE) facility (Designated Provider). To enroll in the program and find the closest COE provider, call 1-877-214-2930 and ask to speak with a. SJS Nurse.

You must enroll in the SJS Program to access benefit coverage for spine and joint procedures. Failure to enroll in the program may result in no coverage for your spine & joint procedure.

Enhanced travel benefits may be available to participants who enroll in this program and utilize a Center of Excellence (COE) facility (Designated Provider) for their eligible surgery. See *Travel and Lodging* for details.

As part of the SJS program, most facilities will cover costs related to complications that result from the surgery for a period of 90 days after the surgery. Claims incurred during this period of time will be reviewed to determine if they were a complication related to the surgery or a readmission to the COE and, as a result, if this feature applies.

Benefits are available for spine and joint services that meet the definition of a Covered Health Service, as defined in Section 12, *Glossary* and are not Experimental or Investigational or Unproven Services.

Please remember Non-Network Benefits for inpatient spine and joint surgery are not available.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember, for Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as soon as is reasonably possible.
- In addition, for Non-Network Benefits you must obtain prior authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance-related and addictive disorders.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement
For Non-Network Benefits for sleep apnea surgery, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration (FDA)*-approved TMJ implants only when all other treatment has failed.

Any combination of Network Benefits and Non-Network Benefits for oral appliances and associated expenses is limited to a $1,500 maximum per Covered Person per lifetime.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis* (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

*Non-Network dialysis is *not* covered under the Plan.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement

For Non-Network Benefits for the following outpatient therapeutic services you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MRI guided focused ultrasound.

If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

The Plan pays Benefits for organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Designated Provider, Network facility that is not a Designated Provider or a non-Network facility.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
For Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Provider, Network Benefits will not be paid. Non-Network Benefits will apply.

For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

For non-Network Benefits, if you don't obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Travel and Lodging Assistance Program

Travel and Lodging assistance is available under the Plan for you or your eligible family member only if you meet the qualifications for the benefit, including receiving care at a Designated Provider that is more than 50 miles from your home address. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The SJS services program provides a maximum of $2,000 per Covered Person per procedure for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 12, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section. Benefits under this section are not available for services to treat a condition that does not meet the definition of Urgent Care.

Virtual Visits

The Plan provides Benefits for virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Vision Examinations

The Plan pays Benefits for:

- Vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment).
- One routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every calendar year.
- Non routine vision exam and refraction eye exam (Vision Exam - medical/surgical eye care is typically problem-oriented, involving the use of medication and/or surgical procedures to diagnose and treat eye problems, such as glaucoma, pink eye and cataracts. Refractive eye exam – external and internal exam, neurological integrity, pupillary reflexes, versions, biomicroscopy, tonometry, visual acuity, subjective, refraction, accomodative function, binocular function).

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from treatment of malignancy or permanent loss of hair from an accidental injury.

Any combination of Network Benefits and Non-Network Benefits is limited to a $500 maximum per Covered Person per lifetime.

SECTION 6 - CLINICAL PROGRAMS AND SERVICES

What this section includes:
Health and well-being resources available to you, including:
- Condition Management Services; and
- Telephonic Wellness Coaching.

The Company believes in giving you the tools you need to be an educated health care consumer. To that end, the Company has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the Company are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that the Company has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drug products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are available when you log onto **www.myuhc.com**;
- search for Network providers available in your Plan through the online provider directory;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information;
- view and print all of your Explanations of Benefits (EOBs) online; and
- order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports Covered Persons who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 5, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS).*

Condition Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a condition management program at no cost to you. The heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition. These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the condition management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate Covered Persons and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 12, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Telephonic Wellness Coaching

The following provides a description of and the eligibility criteria for each Wellness Coaching program:

Tobacco Cessation Program

A tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support throughout the quitting process for up to one year via toll-free phone and live chat.
- Nicotine replacement therapy (patch, lozenge or gum) sent to you in conjunction with your quit date.

- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in the Quit For Life® program, or if you would like additional information regarding the program and also how to access the program online, please call the number on the back of your ID card.

Stress Management Program

UnitedHealthcare's stress management program will provide you with information to help you manage stress through positive behavioral changes.

UnitedHealthcare will identify Covered Persons who are eligible for the stress management program based on the following criteria:

- Covered Persons who feel tense, anxious, or depressed often and stress has had a noticeable impact on health a lot over the past year.

Nutrition Management Program

UnitedHealthcare's nutrition management program will provide you with information designed to increase your awareness of the importance of proper nutrition, and setting dietary goals, and making lifestyle changes. UnitedHealthcare will identify Covered Persons eligible for the nutrition management program based on the following criteria:

- Covered Persons having a BMI of greater than or equal to 25 and less than 30 and 5-6 servings of high cholesterol food per day. BMI greater than or equal to 30 is prioritized to the weight management program.

Exercise Management Program

UnitedHealthcare's exercise management program will provide you with information to assist you in developing an appropriate exercise regime, giving consideration to factors such as age, weight and other health-related conditions. UnitedHealthcare will also provide exercise educational materials. UnitedHealthcare will identify Covered Persons eligible for the exercise management program based on the following criteria:

- Covered Persons with a BMI of greater than or equal to 25 and less than 30 and have physical activity less than one time per week. BMI greater than or equal to 30 is prioritized to the weight management program.

Heart Health Lifestyle Management Program (Blood Pressure/Cholesterol)

The heart health lifestyle management program provides you with an overall understanding of the factors that affect heart health, such as blood pressure and cholesterol. You receive assistance in making lifestyle changes to reduce risks, in addition to guidance on factors that increase risks, such as lack of proper nutrition and exercise. The identification/stratification criteria for the heart health lifestyle management program are as follows:

- self-report excess weight with a BMI > 25; or
- Covered Person has at least one of the following risk criteria:
  - systolic BP = >/=140 or Diastolic BP = ./=90
  - high Blood Pressure and is on medication
  - cholesterol = 240 or HDL < 40
  - indicates has high cholesterol & is on medication
  - high LDL
  - indicates has heart problems, but no heart failure
- BMI greater than or equal to 30 is prioritized to the weight management program.

Diabetes Lifestyle Management Program

The diabetes lifestyle management program is designed to educate you on proper diet, weight loss/ management and exercise. You receive educational materials and guidance focused on prevention through diet, weight loss management, exercise and, when applicable, compliance with prescribed medication.

The identification/stratification criteria for the diabetes lifestyle management program are as follows:

- Covered Persons who indicate they have diabetes and self-report excess weight with a BMI > 25. BMI greater than or equal to 30 is prioritized to the weight management program.

Wellness Programs

Real Appeal Program

UnitedHealthcare provides the Real Appeal program, which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Coinsurance or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325). TTY users can dial 711 or visit **www.realappeal.com**.

Healthy Pregnancy Program

If you are pregnant and enrolled in the Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 7 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:
- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 5, *Additional Coverage Details.*

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 4, *Plan Highlights.* Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 4, *Plan Highlights.* Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the Benefit Booklet says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Benefit Booklet specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing (holistic tissue massage).
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health.*

This exclusion does not apply to Manipulative/Chiropractic Treatment and non-manipulative/chiropractic osteopathic care for which Benefits are provided as described in Section 5, *Additional Coverage Details.*

Dental

1. Dental implants or root canals, orthodontic braces, removal of teeth and intra-bony cysts, procedures performed for the preparation of the mouth for dentures, except as identified under Dental Treatment Covered under Plan in Section 5, *Additional Coverage Details.*

2. Treatment for the following conditions:
   - injury related to chewing or biting;
   - preventive dental care, diagnosis or treatment of or related to the teeth or gums;
   - periodontal disease or cavities and disease due to infection or tumor.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement.

For information on your dental coverage, contact your Dental Plan provider.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

3. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen prosthetic devices.

5. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details.*

6. Oral appliances for snoring.

7. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details.*

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill (See your CVS Caremark Prescription Drug Benefit Booklet for information about the Plan's prescription drug benefit).

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Clomiphine (e.g., Clomid®), menotropins (e.g., Repronex®), or other drugs associated with conception by artificial means.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

2. Treatment of flat feet.

3. Treatment of subluxation of the foot.

4. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.
   - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
   - Voice modification surgery.
   - Voice lessons and voice therapy.

2. Reversal of tubal ligation or vasectomy.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - Compression stockings, ace bandages, diabetic strips, and syringes.

   This exclusion does not apply to:

   - Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in Section 5, *Additional Coverage Details.*
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details.*

- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *Additional Coverage Details.*

2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen Durable Medical Equipment.

5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 5, *Additional Coverage Details.*

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 7, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 5, *Additional Coverage Details.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder.

4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Transitional Living services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Food of any kind. Foods that are not covered include:

   - nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Food is covered only when the sole source of nutrition and administered via enteral feeding (tube feeding). Infant formula available over the counter is always excluded;
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

3. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement;
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.
   - Motorized beds, non-Hospital beds, comfort beds and mattresses.

- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 12, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs regardless of the reason for the hair loss except for treatment of malignancy or permanent loss of hair from an accidental injury, in which case the Plan pays up to a maximum of $500 per Covered Person per lifetime.

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. Rehabilitation services and Manipulative/Chiropractic Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders.

5. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy* in Section 5, *Additional Coverage Details.*

6. A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

8. Psychosurgery (lobotomy).

9. Treatment of tobacco dependency, excluding screenings and counseling;

10. Chelation therapy, except to treat heavy metal poisoning.

11. Manipulative/chiropractic Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies

12. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

13. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 5, *Additional Coverage Details* and the other requirements described under *Obesity Surgery* in Section 5, *Additional Coverage Details,* are satisfied.

14. Medical and surgical treatment of excessive sweating (hyperhidrosis).

15. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.

16. Breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.

17. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

    - Has not been actively involved in your medical care prior to ordering the service.
    - Is not actively involved in your medical care after the service is received.

    This exclusion does not apply to mammography.

6. Services and supplies provided at Cancer Treatment Centers of America are not covered under the Plan.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

This exclusion does not apply to services required to treat or correct underlying causes of infertility;

2. Surrogate parenting, donor eggs, donor sperm and host uterus;

3. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);

4. The reversal of voluntary sterilization;

5. The reversal of tubal ligation or vasectomy;

6. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

7. Health services and associated expenses for elective surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage);

8. Services provided by a doula (labor aide);

9. Parenting, pre-natal or birthing classes.

10. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 9, *Coordination of Benefits (COB).*

2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you.

3. While on active military duty.

4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except as identified under *Transplantation Services* in Section 5, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 5, *Additional Coverage Details.* Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details.*

Types of Care

1. Custodial Care as defined in Section 12, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 12, *Glossary;*

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Provider concierge services.

5. Private Duty Nursing received on an inpatient basis.

6. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details.*

7. Rest cures.

8. Services of personal care attendants.

9. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3 Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

4. Eye exercise or vision therapy.

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan.
   - That exceed Eligible Expenses or any specified limitation in this Benefit Booklet
   - For which a non-Network provider waives the Annual Deductible or Coinsurance amounts.

6. Foreign language and sign language services.

7. Long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

10. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

11. Health services and supplies that do not meet the definition of a Covered Health Service – as defined in Section 12, *Glossary.* Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Benefit Booklet under Section 5, *Additional Coverage Details* and in Section 4, *Plan Highlights.*
    - Not otherwise excluded in this Benefit Booklet under this Section 7, *Exclusions and Limitations.*

SECTION 8 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Deductible or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or by visiting the Duke Energy Portal. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.

- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non- Network provider is made, Duke Energy and the Plan reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes Duke Energy or the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 9. *Coordination of Benefits.*

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the following:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the denial;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- a description of the Plan's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action;
- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the denial, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in

making the denial and that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request;

- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- in the case of a denial concerning an Urgent Care claim, a description of the expedited review process applicable to such claims; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 12, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 18 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 18 month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

This section describes what happens if a claim for Benefits is denied, how you can appeal a denied claim and the first and second level internal appeals processes. At the end of this section is a table which describes the time frames that you and UnitedHealthcare are required to follow in connection with the internal claims and appeals processes.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a concurrent claim determination, including a rescission of coverage, as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.

- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 740809
Atlanta, Georgia 30374

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal, and will take into account all comments, documents, records and other information you submit relating to your claim for Benefits, without regard to whether such information was submitted or considered in the initial denial. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

To the extent required by applicable law, UnitedHealthcare will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan (or at the direction of the Plan) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, to the extent required by applicable law, if the denial of your appeal is based on a new or additional rationale, UnitedHealthcare will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. The written explanation will include the following:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination of your appeal;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the determination of your appeal is based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim;
- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate the external appeal process;
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action and about any available voluntary alternative dispute resolution options;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request;
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination. UnitedHealthcare must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and within 30 days after receiving the completed post-service appeal. Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial which will include the information specified above with respect to your first appeal, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments.

UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. UnitedHealthcare's decision will be final, unless overturned through the Federal External Review Program described below.

Once you have exhausted the internal claims and appeals process described above, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. See "Federal External Review Program" below for additional information.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims and appeals, depending on the type of claim or appeal. There are three types of claims and appeals:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service claim- a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**

If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal a denied Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal
*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.	

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance

with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision. If you do not submit a request for standard external review within four months after the date you received UnitedHealthcare's decision, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was requested or provided.
- Did not have the claim denied due to a failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is complete but is not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Department of Labor's Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials necessary to make the request complete. You must provide the required information to UnitedHealthcare within the original four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If you do not provide the required information by the applicable deadline, the claim will be deemed permanently waived and abandoned and you will be precluded from reasserting it under these procedures.

If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives

the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, the IRO considered in reaching its decision;
- a discussion of the principal reason or reasons for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of

care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you as described above with respect to the Standard External Review Process. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator unless you first complete all the steps in the internal appeal processes described in this section. After completing this process, if you want to bring a legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator, you must do so within one year following a final decision on the claim under the internal appeal processes or you lose any rights to bring such an action against the Company, the Plan, the Plan Administrator or the Claims Administrator.

SECTION 9- COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term "allowable expense" is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.

- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Only expenses normally paid by the Plan will be paid under COB.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, the Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan may pay an additional amount.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two plans' reasonable and customary charges. If the Plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare.*

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older;
- Individuals with end-stage renal disease, for a limited period of time; and
- Participants not actively working and receiving long-term disability benefits for up to six months.

After a participant who is not actively working has received long-term disability benefits for six months, the Plan will pay Benefits second to Medicare.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare.

If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carrier have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This cross-over process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the

overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name, or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you or your dependents, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been contributed to or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.

- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 11 - OTHER IMPORTANT INFORMATION

What this section includes:

- Your relationship with UnitedHealthcare and the Company.
- Relationships with providers.
- Incentives to providers and you.

Your Relationship with UnitedHealthcare and the Company

In order to make choices about your health care coverage and treatment, the Company believes that it is important for you to understand how UnitedHealthcare interacts with the Plan and how it may affect you. UnitedHealthcare helps administer the Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The Company and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this Benefit Booklet).
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between the Company, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not the Company's agents or employees, nor are they agents or employees of UnitedHealthcare. The Company and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees, agents or employees of Network providers.

The Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the Company and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Company's employees nor are they employees of UnitedHealthcare. The Company and UnitedHealthcare do not

have any other relationship with Network providers such as principal-agent or joint venture. The Company and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employee of the Company for any purpose with respect to the administration or provision of benefits under this Plan.

The Company and the Plan Administrator are solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination of or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as a participant responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.

Information and Records

UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. UnitedHealthcare may request additional information from you to decide your claim for Benefits. UnitedHealthcare will keep this information confidential.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan Administrator and UnitedHealthcare with all information or copies of records relating to the services provided to you. The Plan Administrator and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents. The Plan Administrator and UnitedHealthcare agree that such information and records will be considered confidential.

The Plan Administrator and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan Administrator is required to do by law or regulation. During and after the term of the Plan, the Plan Administrator and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements you should contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary.

UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but you should discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for

any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

SECTION 12 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this Benefit Booklet.

Many of the terms used throughout this Benefit Booklet may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefit Booklet, but it does not describe the Benefits provided by the Plan.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year (other than Benefits for Network preventive care services which are paid at 100% by the Plan even before you satisfy your Annual Deductible). The Deductible is shown in the first table in Section 4, *Plan Highlights*.

Annual Enrollment - the period of time, determined by Duke Energy, during which eligible Employees may enroll themselves and their Dependents under the Plan. Duke Energy determines the period of time that is the Annual Enrollment period.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The BRS program provides:

- Specialized clinical consulting services to Covered Persons to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The CRS program provides:

- Specialized consulting services, on a limited basis, to Covered Persons with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works.*

Company - Duke Energy Corporation and its affiliated companies that are participating in the Plan.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health coverage to certain employees and their dependents whose group health coverage has been terminated.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this Benefit Booklet under Section 4, *Plan Highlights* and Section 5, *Additional Coverage Details.*
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in the General Information Booklet.
- Not otherwise excluded in this Benefit Booklet under Section 7, *Exclusions and Limitations.*

Covered Person – the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person. For purposes of the wellness programs described in Section 6. *Clinical Programs and Services*, "Covered Person" means all domestic Employees who are eligible for the Plan, their Dependents age 18 and over who are eligible for the Plan and each other person who is eligible for the Plan and elects to participate in the wellness program, regardless of whether such person also elects to participate in the Plan.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the General Information Booklet.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by UnitedHealthcare as stated below and as detailed in Section 2, *How the Plan Works.*

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employee – an individual who meets the eligibility requirements described in the General Information Booklet.

Employer - Duke Energy Corporation.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

EOB - see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)

- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*
- If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.

  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical,

mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.

- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The KRS program provides:

- Specialized consulting services to Covered Persons with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative/Chiropractic Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or

rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Sickness, Injury, Mental Illness, substance related and addictive disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Sickness, Injury, Mental Illness, substance related and addictive disorder, disease or its symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UnitedHealthcareOnline.com**.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical*

Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Services Administrator - the organization or individual designated by the Plan Administrator who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 7, *Exclusions and Limitations.*

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 4, *Plan Highlights,* and Section 2, *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 4, *Plan Highlights,* and Section 2, *How the Plan Works*, for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - the maximum amount you pay every calendar year. Refer to Section 4, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 2, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Health Savings Plan 2 Option under the Duke Energy Active Medical Plan and/or the Duke Energy Active Medical Plan, as appropriate depending on context, each as amended from time to time.

Plan Administrator – The Duke Energy Benefits Committee or its designee.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore

physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan Coinsurance and Deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Benefit Booklet includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Spouse – your spouse or domestic partner as defined in the General Information Booklet.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program – a program that identifies network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.

- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your Claims Administrator.

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်၊ စကားပြန်တစ်ဦးတောင်းဆိုရန် သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꭴ ÞP ᎫCZᏢᎫ Ꭻ4ᏫᎯ ᏂᎪᏯᏔW ᎥᏓ ᏩᏙP ᏗᎯ ÞR ᎫJAᏗᎫ ACᏫᎯᏗ ᎢΘᏂᏫᎯT, ᎣᏣ0ᏯᏫᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。
28. Karen	[illegible] TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	ماقەی نەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەلای نای دی کارتی پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meļeļe ilo kajin eo aṃ ilo ejjeļoļk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrļok nōṃba eo emōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.

Language	Translated Taglines
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wëërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ਼ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveţi dreptul de a obţine gratuit ajutor şi informaţii în limba dumneavoastră. Pentru a cere un interpret, sunaţi la numărul de telefon gratuit care se găseşte pe cardul dumneavoastră de sănătate, apăsaţi pe tasta 0. TTY 711

Language	Translated Taglines
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Dum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܝܬܠܘܟ ܐܝܬܠܘܟ ܫܘܠܛܢܐ ܕܦܠܚܬܘܟ ܫܘܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟ ܡܓܢܐܝܬ ܠܡܫܐܠܬܐ ܡܢ ܚܕ ܡܬܪܓܡܢܐ ܩܪܝ ܠܡܢܝܢܐ ܕܐܝܬܠܗ ܥܠ ܟܪܛܝܣܐ ܕܫܘܠܛܢܐ ܕܐܝܠܗ ܗܕܐ ܕܚܘܠܡܢܐ ܘܡܚܝ 0. TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711

Language	Translated Taglines
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייַ מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דדוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

CVS caremark™

Prescription Drug Program Guide for the Duke Energy Active Medical Plan

TABLE OF CONTENTS

SECTION 1 – WELCOME

The Duke Energy Active Medical Plan ("Medical Plan") options include outpatient prescription drug coverage currently administered by CVS Caremark. CVS Caremark works with Duke Energy Corporation ("Duke Energy") (individually or collectively referred to with its affiliated companies as the "Company," as appropriate) to help you improve your health and make informed health care decisions, as well as save money on your prescription drugs.

Your prescription drug program benefits through CVS Caremark include the following features:

- The CVS Caremark retail network consists of more than 64,000 participating retail pharmacies.
- Your long-term prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy.
- Online resources are available at **www.Caremark.com** to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- You can reach CVS Caremark Customer Service representatives, 24 hours a day, 7 days a week at 888-797-8912. Pharmacists are also available around the clock for medication consultations.

CVS Caremark will help protect your privacy as follows:

- CVS Caremark employees follow detailed ethical standards and a comprehensive Code of Conduct regarding your personal health information.
- CVS Caremark pharmacists follow a professional Code of Ethics.

SECTION 2 – HOW THE PROGRAM WORKS

Prescription Drug Coverage under the Health Savings Plan (HSP) Options

Because you are enrolled in a Health Savings Plan (HSP) option under the Medical Plan, you pay 100% of CVS Caremark's negotiated price for your prescription drug purchases (other than preventive medications, as described below) at retail pharmacies and through the CVS Caremark Mail Service Pharmacy until you meet the applicable Medical Plan annual deductible under your HSP option[1].

If you use a pharmacy that is participating in the CVS Caremark retail network, once you meet your applicable annual deductible, the HSP option pays eligible prescription drug expenses at 80% coinsurance and you pay 20% until you reach the applicable Medical Plan annual out-of-pocket maximum under the HSP option. If you use a pharmacy that is not participating in the CVS Caremark retail network, once you meet your applicable annual deductible, the HSP option pays eligible prescription drug expenses at 60% coinsurance and you pay 40% until you reach the applicable Medical Plan annual out-of-network, out-of-pocket maximum under the HSP option. The applicable annual out-of-pocket maximum under the HSP option is a combined out-of-pocket maximum that applies to both medical and prescription drug expenses under the Medical Plan. After you reach the applicable annual out-of-pocket maximum, the HSP option pays 100% of your eligible prescription drug purchases for the remainder of the calendar year.

If you use any medications on a long-term basis, ordering your medications through the CVS Caremark Mail Service Pharmacy may still help you maximize savings.

Remember: Under the HSP option, your eligible medical expenses and your eligible prescription drug purchase amounts apply to the HSP option's annual deductible and you pay 100% of your eligible expenses (excluding certain preventive care services and preventive medications) until you reach the deductible.

As you make prescription drug purchases for each covered individual, the receipts you receive can help you track your progress toward meeting the annual deductible. You may also call CVS Caremark Customer Service to determine the portion of the deductible that has been satisfied to date.

[1] *For in-network benefits under the HSP option, you must satisfy an annual individual deductible if only you are covered or an annual family deductible if one or more of your eligible dependents also is covered.*

Filling Your Prescription at a Pharmacy Participating in the CVS Caremark Retail Network

You can fill a prescription for up to a 30-day supply at any of over 64,000 retail pharmacies participating in the CVS Caremark retail network. You will simply show your CVS Caremark prescription ID card at the time of your purchase. You will pay 100% of your non-preventive prescription drug purchases until you meet the applicable Medical Plan annual deductible under your HSP option, after which you pay a coinsurance amount. Once you meet the applicable Medical Plan annual out-of-pocket maximum under your HSP option, the Medical Plan pays for your eligible prescription drug purchases at 100%.

- If you don't identify yourself to the pharmacist as a CVS Caremark participant, or if you go to a pharmacy that is not participating in the CVS Caremark retail network, you will have to pay the full price for non-preventive prescription drug purchases, even if you have already met the applicable Medical Plan annual deductible or annual out-of-pocket maximum under your HSP option, when you pick up the prescription and then submit a paper claim to CVS Caremark for reimbursement. You will be reimbursed based on the CVS Caremark negotiated price for the medication, less any required deductible and coinsurance. Retail pharmacies that participate in the CVS Caremark retail network fill prescriptions at an agreed upon discounted price. When you fill prescriptions at a non-participating retail pharmacy, or do not identify yourself as a CVS Caremark participant, you may be charged a price higher than the negotiated price and the result is a higher cost prescription to you.
- If you make a non-preventive prescription drug purchase at a pharmacy that is participating in the CVS Caremark retail network, do not identify yourself as a CVS Caremark participant by presenting your CVS Caremark prescription ID card and are required to pay full price for the non-preventive prescription drug purchase, generally, you have up to 14 days from the time your prescription was purchased to return to the pharmacy, present your CVS Caremark prescription ID card and ask the pharmacist to submit the order using the original dispensing date. Please confirm at the time you make your purchase that you can return to have your purchase re-processed. You may be entitled to a refund for the difference between the full price and your applicable deductible and coinsurance. This process will eliminate your need to submit a paper claim to CVS Caremark for reimbursement.

Using the CVS Caremark Maintenance Choice™ Program

Generally, a long-term (maintenance) medication is one that you take on a long-term basis such as those used for diabetes, asthma, high blood pressure, high cholesterol or birth control. If you are taking a long-term (maintenance) medication, you may request that your doctor prescribe 90-day supplies, plus refills as appropriate (three refills maximum) instead of 30-day supplies. Under CVS Caremark's Maintenance Choice program, if you choose to receive 90-day supplies, you must fill your prescription through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy near you.

Fill limit for long-term medications

The Medical Plan allows three 30-day fills of long-term medications at any pharmacy that participates in the CVS Caremark retail network. After that, the Medical Plan will cover long-term medications only if you have 90-day supplies filled through the CVS Caremark Mail

Service Pharmacy or at a CVS retail pharmacy at the applicable 90-day supply coinsurance amount. If you do not use the CVS Caremark Mail Service Pharmacy or a CVS retail pharmacy after the third fill, you will pay 100% of the retail price of the long-term medication.

If you will be obtaining your own prescription, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum).

The list of long-term medications that are part of the Maintenance Choice program is subject to change at any time. Visit **www.Caremark.com** to find out whether your medication is considered a long-term medication and whether it is affected hy any Medical Plan limits, or you may call CVS Caremark directly for more information.

Process for Mail Order Medications
There are several methods you may use to fill your newly prescribed long-term medications through the CVS Caremark Mail Service Pharmacy.

- **Option 1**: Ask your doctor to select the CVS Caremark Mail Service Pharmacy using their provider ePrescribing tools, or your physician may call 800.378.5697.

- **Option 2**: Use the CVS Caremark mobile app for your smart phone to photograph your prescription order and submit the new prescription electronically to the CVS Caremark Mail Service Pharmacy.

- **Option 3**: Get started using the CVS Caremark Mail Service Pharmacy with FastStart®. Log on to www.caremark.com/faststart to provide the requested information, and CVS Caremark will contact your doctor for the 90-day prescription you need. You also can call FastStart® toll-free at 800.875.0867 for assistance.

- **Option 4**: Alternatively. you can complete the mail order form, which is available at www.Caremark.com, and send it with your new prescription order and payment method for any applicable prescription drug annual deductible and co-insurance amounts to the address on the form. If you have any questions about completing the form, contact Customer Service at 888-797-8912.

Once you fill a prescription through the CVS Caremark Mail Service for the first time, you then have the option to use the automated refill service for future refills by CVS Caremark. Visit www.Caremark.com for more information on the Auto Refill process.

Please note: When a prescription is ordered using the CVS Caremark Mail Service Pharmacy, CVS Caremark will automatically dispense the generic equivalent if one is available and permissible by law, unless your physician has indicated that substitution is not allowed.

Using Mail Order if you have an Immediate Medication Need
If you will be using the CVS Caremark Mail Service Pharmacy, but need to begin taking a long-term medication immediately, have your doctor write two prescriptions:

- The first for up to a 30-day supply to be filled right away at any pharmacy that is participating in the CVS Caremark retail network – your doctor can call/fax this prescription to the pharmacy or provide it to you so you may take it to the pharmacy.
- The second for up to a 90-day supply to be filled through the CVS Caremark Mail Service Pharmacy using one of the methods described above.

Covered Expenses

The following are covered expenses under the Medical Plan unless listed as excluded below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes
- Glucose Monitors
- Over-the-Counter (OTC) Diabetic Supplies (lancets, lancet devices, alcohol wipes)
- Oral, Transdermal, Intravaginal and Injectable Contraceptives
- Contraceptive Emergency kits
- Drugs to Treat Impotency (Limits of 6 units per 30 days at retail, and 18 units per 90 days at mail for all dosage forms except Yohimbine)
- Inhaler Assisting Devices
- Peak flow meters
- Fertility Agents (100% after deductible, if applicable, up to $2,500 per person per lifetime, then participant pays 50% of the cost of the drug)
- Influenza treatments at 1 treatment course per 180 days
- Zyban and Chantix (limit of 360 days of therapy per lifetime)
- Anti obesity Agents
- Products packaged as greater than a 30-day supply are covered through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy only

Excluded Expenses

The following are excluded from coverage under the Medical Plan unless specifically listed as a benefit under "Covered Expenses."

- Non-Federal Legend Drugs
- Non-systemic contraceptives, devices
- Smoking Deterrents (except as listed above)
- Nutritional Supplements
- Ostomy Supplies (covered as a medical expense under the Medical Plan)
- Glucowatch Products
- Mifeprex
- Therapeutic devices or appliances (including Diabetic Pumps and supplies, which are covered as a medical expense under the Medical Plan)
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums (covered as a medical expense under the Medical Plan)

- Biologicals, immunization agents or vaccines (except as noted below for certain routine vaccines)
- Blood or blood plasma products (covered as a medical expense under the Medical Plan)
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or from any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the participant
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug
- New-to-market unapproved products and certain existing unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act (FFDCA)
- Arestin (covered as a dental expense under the Duke Energy Active Dental Plan)

Medical Plan and Health Savings Account

If you have established a Health Savings Account and sufficient funds are available in your account, you may choose to pay any prescription drug annual deductible and coinsurance amounts with before-tax dollars by using your HSA debit card or checkbook.

Medical Plan and Health Care Spending Account

If you have enrolled in a Health Care Spending Account (HCSA) and are eligible to access HCSA funds, you may pay any prescription drug annual deductible and coinsurance amounts with before-tax dollars by filing for reimbursement from your HCSA or using your HCSA debit card.

SECTION 3 – COVERAGE DETAILS

CVS Caremark Primary/Preferred Drug List

Your cost for prescription purchases will vary depending on whether your physician prescribes a generic, preferred brand or non-preferred brand medication. By asking your physician to prescribe generic or preferred brand medications, you can help control rising health care costs.

Your prescription drug program incorporates a Primary/Preferred Drug List which lists the Medical Plan's preferred brand medications. The medications included on the list, which change from time to time, are commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings for the participant and the Medical Plan. For the most recent listing and to find out whether a medication is included in the Primary/Preferred Drug List, visit CVS Caremark online at **www.Caremark.com** or call CVS Caremark Customer Service at 888-797-8912. This listing is also available for viewing by employees on the Duke Energy Portal.

Refer to the prescription drug program summary of benefits on page 21 for more information about applicable coinsurance amounts for generic, preferred brand and non-preferred brand medications.

Preventive Medications

CVS Caremark maintains a list of certain medications prescribed to prevent the occurrence/re-occurrence of chronic illnesses. This list is referred to as the Preventive Therapy Drug List. Under your HSP option, preventive medications included on the Preventive Therapy Drug List are covered at 100% and are not subject to your HSP option's co-insurance or deductible when you use either a pharmacy that is participating in the CVS Caremark retail network or the CVS Caremark Mail Service Pharmacy to fill those prescriptions. This means that the Medical Plan will cover 100% of the cost and you will pay nothing, even if you have not met the applicable Medical Plan annual deductible.

Preventive medications are those items used to address risk factors for a disease that has not yet manifested itself, or to prevent the reoccurrence of a disease. Preventive medications do not include drugs for treatment of an existing illness or condition. A copy of the current Preventive Therapy Drug List is available on **www.Caremark.com**. CVS Caremark develops the Preventive Therapy Drug List in accordance with FDA and IRS guidelines regarding the types of medications that are considered "preventive" and therefore may be covered under your HSP option before the required deductible is satisfied. The Preventive Therapy Drug List is periodically updated to reflect new guidance issued and/or new drugs on the market.

Certain Contraceptive Medications Covered at 100%

The following contraceptive medications are covered at 100% (i.e., you do not pay anything when you purchase these items) when received from a pharmacy that is participating in the CVS Caremark retail network or the CVS Caremark Mail Service Pharmacy:

- Generic contraceptive medications; and

- Brand contraceptive medications where there is no generic available.

Note: If a generic version of a brand contraceptive medication becomes available, then only the generic contraceptive medication will be covered at 100%.

Certain Routine Vaccines Covered at 100%

The Medical Plan provides coverage for certain commonly administered vaccines at 100% when you present your CVS Caremark prescription ID card at a pharmacy that is participating in the CVS Caremark retail network. This is an alternative to getting certain immunizations from your doctor. Commonly administered vaccines available at a participating pharmacy through the Medical Plan include the following, where applicable:

- Hepatitis A (Adult)
- Hepatitis A (Child)
- Hepatitis B (Adult)
- Hepatitis B (Child)
- Human Papillomavirus (Gardasil)
- Influenza (Fluzone)
- Meningitis
- MMR (Measles, Mumps, Rubella)
- Pneumonia (Pneumovax)
- Polio (IPV)
- Shingles vaccine (Zostavax)
- TD (Tetanus, Diphtheria)
- Tdap (Tetanus, Diphtheria, Pertussis)

Please Note: Not all local pharmacies are staffed to provide immunizations and some may require a prescription to administer the vaccine based on requirements of particular states. Check with your local pharmacy for vaccine availability before you go.

CVS Caremark Specialty Medications and Specialty Guideline Management

Duke Energy participates in the CVS Caremark Specialty Guideline Management Program. This program supports safe, clinically appropriate and cost-effective use of specialty medications. Under your prescription drug program, some specialty medications may only be covered when ordered through CVS Caremark's specialty care pharmacy. CVS Caremark is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling.

Certain specialty medications such as treatments for Growth Hormone and related disorders, Hepatitis C, Multiple Sclerosis and Anemia will have additional management that ensures that the specialty medication continues to have appropriate lab testing and data reviewed to help ensure utilization of these specialty medications to be:

- clinically appropriate;
- safe; and

- effective for the patient throughout the duration of therapy.

For continued treatment with one of these specialty drugs, a periodic clinical review is required. CVS Caremark will obtain the necessary clinical information from your doctor's office and conduct the review.

The CVS Caremark Specialty Pharmacy provides not only your specialty medicines, but also personalized pharmacy care management services:

- Access to an on-call pharmacist 24 hours a day, seven days a week
- Coordination of care with you and your doctor
- Convenient delivery directly to you or to your doctor's office
- Medicine- and disease-specific education and counseling
- Online support through **www.Caremark.com/specialty**, including disease-specific information and interactive areas to submit questions to pharmacists and nurses

If a covered participant uses medications that are classified by CVS Caremark as specialty medications and wishes to use the prescription drug benefit, the participant should obtain these medications from CVS Caremark Specialty Pharmacy Services. Most of these same drugs also require prior authorization from CVS Caremark, as described below. These drugs are typically only available in up to a 30-day supply, even if taken on a long-term basis.

All specialty medications undergo external review of the program guidelines by clinical experts to ensure the program is unbiased and consistent with current standards of care and practice.

To answer any questions you may have about specialty medications or to find out what medications are considered to be specialty medications for purposes of the Medical Plan, you may contact CVS Caremark Specialty Pharmacy Services directly at 800-237-2767.

SECTION 4 – SPECIAL PROGRAMS

Step Therapy Program

In order to have coverage for prescription medications in certain drug classes, you must try a generic medication first to treat your condition. If you try (or have tried) a generic medication and it does not work for you, then you may receive coverage for a preferred brand medication that your doctor prescribes. If you try (or have tried) a preferred brand medication and it does not work for you, then you may receive coverage for a non-preferred brand medication that your doctor prescribes.

The amount you pay for your prescription will be lowest when you choose a generic medication. If no generic is available – or if it is not right for you – your Medical Plan provides coverage for preferred brand medications, which may also save you money.

However, if you choose to use a preferred brand medication without trying a generic first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the preferred brand medication. If you choose to use a non-preferred brand medication without trying a generic and preferred brand first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the non-preferred brand medication.

For information regarding the drug classes subject to the Step Therapy Program, call CVS Caremark at 888-797-8912.

Maximum Drug Limitation Program

The Medical Plan prescription drug benefits include quantity limits on certain medications, which are applied to address the problem of overuse of medications that can be unsafe for the patient. By following these guidelines, participants are assured of receiving the appropriate safe dosage recommended by the FDA. This means that:

- The Medical Plan will pay only for up to a specified quantity per 30- or 90-day periods.
- In addition, some medications have limitations on the day's supply of medication that may be dispensed to a patient at any one time.
- In certain drug classes, if the medical condition warrants a greater quantity than the established quantity limit, CVS Caremark will discuss the patient's needs with the patient's physician to determine if a greater quantity is medically necessary to treat the condition.

For information regarding the medications subject to the Maximum Drug Limitation Program, call CVS Caremark at 888-797-8912.

Prior Authorization

To ensure that drugs covered by the Medical Plan are used safely and appropriately, certain medications require that physicians obtain prior authorization from CVS Caremark *before* they are covered. Other classes may be added based upon safety, efficiency and FDA approved therapies. Call CVS Caremark at 888-797-8912 to determine if a medication requires prior authorization. Prior authorization does not guarantee coverage or payment under the Medical Plan.

Prior authorization also is required for a preferred brand medication to be covered prior to trying a generic medication, and for a non-preferred brand medication to be covered prior to trying a generic and preferred brand medication, as described above.

In order for medications which require prior authorization to be covered under the Medical Plan, your physician must obtain authorization from CVS Caremark at 800-294-5979 in advance of treatment with these medications.

Drug Utilization Reviews

Drug utilization reviews may help you guard against drug interaction problems that can occur, for example, when medications are prescribed by more than one physician. When your prescriptions are filled through the CVS Caremark Mail Service Pharmacy or at a pharmacy that is participating in the CVS Caremark retail network (using your CVS Caremark prescription ID card), they are reviewed for any potential drug interactions. This review is especially important if you or your covered family members take several medications or see more than one physician. If there is a question about your prescription, a registered pharmacist may contact your physician before dispensing the medication to discuss any alternatives and recommendations. You will be notified of any change in your prescribed medication. Your doctor makes the final decision on all of your prescription medications.

SECTION 5 – COORDINATION OF BENEFITS

Under the prescription drug program, CVS Caremark will not coordinate benefits for prescription drug expenses with other coverage you may have. That is, if you and/or your covered family members have prescription drug coverage under another plan, you may submit your prescription drug claims to whichever plan you choose. For example, if your spouse/domestic partner's medical plan does not cover prescription drugs or requires a higher deductible and coinsurance amount, you may want to use your CVS Caremark prescription ID card, instead of your spouse/domestic partner's plan, to obtain your prescriptions. Alternatively, if your spouse/domestic partner's medical plan requires co-pays to purchase prescription medications in lieu of deductibles and coinsurance, you may want to use your spouse/domestic partner's plan, instead of your CVS Caremark prescription ID card, to obtain your prescriptions.

SECTION 6 – CLAIMS PROCEDURES

How to File a Prescription Drug Program Claim

When you fill your prescription at a pharmacy that is participating in the CVS Caremark retail network and identify yourself as a CVS Caremark participant, you will not have to file a claim form. At the time your prescription is filled, you will have to pay the applicable deductible or coinsurance amount.

If you do not identify yourself to the pharmacist as a CVS Caremark participant, or if you do not use a pharmacy that is participating in the CVS Caremark retail network, you will need to file a claim for reimbursement of your prescription drug expenses through CVS Caremark. When you submit your claim, attach your original receipts and mail your claim to the address shown on the form. An original receipt should show the date of purchase, the name, cost, strength, quantity and days' supply of the medication, the prescription number and the NDC number. When you submit an original receipt, keep a copy for your records. Claim reimbursement is limited to CVS Caremark's discounted price less any required deductible and coinsurance.

CVS Caremark will consider claims for payment, provided your prescription claim is filed within 15 months from the date of service. Claims filed after 15 months from the date of service will not be considered for payment. For example, if you purchase a covered prescription medication on January 15, 2018, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2019 to receive reimbursement for your expenses.

If you are newly eligible, you have a 45-day grace period for prescription drug claims for purchases at full cost in situations where the prescription ID card was not used. The grace period allows participants to be reimbursed at 100%, less the applicable deductible and coinsurance, for paper claims submitted within 45 days from a participant's initial eligibility effective date with CVS Caremark. For example, a participant who's initial effective date with CVS Caremark is January 1, 2018 would have 45 days (until February 14, 2018) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

To obtain a claim form, call CVS Caremark Customer Service at 1-888-797-8912, or go online to **www.Caremark.com**.

Submit claim forms to:
CVS Caremark
P.O. Box 52196
Phoenix, AZ 85072-2196

Reviews & Appeals

The timing for review of your claim depends on the type of claim you submit, as described below. You may designate an authorized representative to assist you with the claims and appeals process described below.

Review Timing for Post-Service Claims
In the case of a post-service claim, CVS Caremark will notify you of the determination within 15 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CVS Caremark's control, it will notify you within 15 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed. The determination period will be suspended on the date CVS Caremark sends such a notice of missing information, and the determination period will resume on the date you respond to the notice. You will have at least 45 days to respond to the request for information.

For these purposes, a post-service claim is any claim that is not a pre-service claim or an urgent care claim, each as defined below.

Review Timing for Pre-Service Claims (Claims Relating to Prior Authorization)
In the case of a pre-service claim, CVS Caremark will inform you of its decision (whether adverse or not) within a reasonable period of time appropriate to the medical condition, but not later than 15 days after it receives the claim. Under special circumstances, CVS Caremark may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which CVS Caremark expects to render a decision.

If additional information is needed because necessary information is missing from the request, the notice will specify what information is needed. You must provide the specified information to CVS Caremark within 45 days after receiving the notice. The determination period will be suspended on the date CVS Caremark sends a notice of missing information and the determination period will resume on the date you respond to the notice.

If you have not followed the proper procedures for filing your pre-service claim, you will be notified of the failure and the proper procedures to be followed in filing pre-service claims. This notice will be provided to you as soon as possible, but not later than 5 days, following the failure. This notification may be oral, unless you request written notification.

For these purposes, a pre-service claim means any claim for a benefit with respect to which the terms of the prescription drug program condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Review Timing for Urgent Care Claims
If your claim is an urgent care claim, CVS Caremark will notify you of its decision on your claim (whether adverse or not) as soon as possible, but no later than 72 hours after it receives the claim. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable, CVS Caremark will inform you as soon as possible, but no later than 24 hours after it receives the claim, of the specific information necessary to complete the claim. You will have a reasonable amount of time, taking into account the circumstances, but no less than 48 hours, to provide the specified information. CVS Caremark will notify you of its determination on your claim as soon as possible, and no later than 48 hours after the earlier of (1) CVS Caremark's receipt of the specified information and (2) the end of the period provided to you to provide the specified additional information.

If you have not followed the proper procedures for filing your urgent care claim, you will be notified of the failure and the proper procedures to be followed in filing urgent care claims. This notice will be provided to you as soon as possible, but not later than 24 hours, following the failure. This notification may be oral, unless you request written notification.

For these purposes, an urgent care claim is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Notice of Adverse Determination
In the event of an adverse benefit determination, in whole or in part, you will be notified of the adverse determination in writing.

An adverse benefit determination is a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Medical Plan benefit. An adverse benefit determination notification for any prescription drug program claim will contain:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the prescription drug program's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your rights to bring a civil action under section 502(a) of ERISA following any final internal adverse benefit determination on appeal and any time limits for filing such a civil action;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;
- a statement that a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim is available free of charge upon request;
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims;

- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If the adverse benefit determination relates to an urgent care claim, the information described above may be provided to you orally within the required time frame, provided that a written or electronic notification is provided no later than 3 days after the oral notification.

When You Have a Complaint or an Appeal
If your claim is denied, you may request a full review by CVS Caremark within 180 days of the date of the adverse benefit determination. Your written letter of appeal should include the following:

- your name and participant ID number;
- your doctor's name and telephone number;
- the name of the medication; and
- any additional information from your pharmacy or medical provider that will assist CVS Caremark in completing its review of your appeal, such as documents, records, questions or comments.

Documents, records, written comments, and other information in support of your appeal should accompany your request. This information will be considered by CVS Caremark in reviewing your claim. You may request reasonable access to copies of all documents, records, and other information relevant to your claim. CVS Caremark will review your claim without granting any deference to the initial decision regarding your claim. Also, no reviewer may be a person that was involved in making the initial decision regarding your claim, or a subordinate to that person. If the claim was based, in whole or in part, on a medical judgment in reviewing the claim, CVS Caremark will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person (or a subordinate of a person) consulted by CVS Caremark in deciding the initial claim. Your appeal should be mailed to:

Caremark, Inc.
Department of Appeals, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

CVS Caremark can also be reached by fax at 866-689-3092. In the case of an appeal relating to an urgent care claim, you may request an expedited appeal orally by contacting CVS Caremark

at 888-797-8912 or in writing. All necessary information will be transmitted by telephone, fax or other available similarly expeditious manner.

To the extent required by applicable law:

- you will be allowed to review your claim file and to present evidence and testimony as part of the internal claims and appeals process;
- CVS Caremark will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the prescription drug program (or at the direction of the prescription drug program) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date; and
- if the denial of your appeal is based on a new or additional rationale, CVS Caremark will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Timing of Appeal Notification for Post-Service Claims
In the case of a post-service claim, CVS Caremark will notify you of its decision on your appeal within 30 days of its receipt of your request for review.

Timing of Appeal Notification for Pre-Service Claims (Claims Requiring Preauthorization)
In the case of a pre-service claim, CVS Caremark will provide notification of its determination on appeal within a reasonable amount of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

Timing of Appeal Notification for Urgent Care Claims
In the case of an urgent care claim, CVS Caremark will provide notification of its determination on appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request for review.

Notice of Benefit Determination on Appeal
Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate the external appeals process;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and your right to bring an action under ERISA section 502(a) following any final internal adverse benefit determination and any applicable time limits for bringing such an action;

- a statement that copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal are available upon request and free of charge;
- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Second Level Appeal Process for Post-Service Claims
If your post-service claim is denied on appeal, you have a right to bring a second appeal within 30 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in "When You Have a Complaint or Appeal" above. CVS Caremark will notify you of its decision on your appeal within 30 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in "Notice of Benefit Determination on Appeal" above, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Second Level Appeal Process for Pre-Service Claims
If your pre-service claim is denied on appeal, you have a right to bring a second appeal within 15 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in "When You Have a Complaint or Appeal" above. CVS Caremark will notify you of its decision on your appeal within 15 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in "Notice of Benefit Determination on Appeal" above, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Voluntary External Review Program
Once you have exhausted the internal claims and appeals process described above, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. External review is available only after internal appeals are exhausted and is available only for certain types of adverse benefit determinations, as defined by federal regulations.

If you wish to file a request for external review, you must submit your request within 4 months of the date of your receipt of CVS Caremark's final internal adverse determination on your

appeal. Contact CVS Caremark at the telephone number shown on your CVS Caremark prescription ID card for more information on how to file a request for external review of your appeal.

CVS Caremark will determine if your appeal is eligible for the voluntary external review program and will provide you with a written notice of its determination. If your request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the request complete, and, in order to pursue an external review, you must provide the required information within the 4-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If your claim is eligible for external review, CVS Caremark will assign your claim to an IRO. The IRO will notify you of the acceptance of your claim for external review, and this notice will include a statement that you may submit to the IRO in writing within 10 business days following receipt of the notice any additional information the IRO should consider in conducting the external review.

The IRO will review all of the information and documents it receives in a timely manner. You will receive written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the prescription drug program;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

If your request for external review relates to an urgent care claim, CVS Caremark will determine if the appeal is eligible for the voluntary external review program and will provide you with written notice of its determination immediately. If the urgent care claim is eligible for external review, CVS Caremark will assign the urgent care claim to an IRO as described above. The IRO will review all of the information and documents relevant to the appeal, to the extent the information and documents are available and the IRO considers them appropriate. The IRO will provide notice to you and the Medical Plan of the final external review decision as soon as possible, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not provided in writing, the IRO will provide you and the Medical Plan with a written confirmation of its decision within 48 hours after the date of providing the notice.

Legal Action
You have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the internal claims and appeals procedure. You may not initiate a legal action until you have completed the first and second level internal appeal processes. No legal action may be brought more than one year following a final decision on the claim under the internal appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority
The authority to decide initial claims for prescription drug program benefits under the prescription drug program and denied claims for prescription drug benefits on review under the prescription drug program includes the full power and discretion to interpret prescription drug program provisions and to make factual determinations, with CVS Caremark's decisions, interpretations and factual determinations controlling, unless overturned through the voluntary external review program described above. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to CVS Caremark at the address listed above. Call CVS Caremark Customer Service for additional information regarding the appeals process.

This is a guide of covered expenses and expenses not covered under the prescription drug program. This guide contains selected highlights of Duke Energy's employee benefits plans. If any statement herein, or any other communication, conflicts with the applicable plan documents, the plan documents will govern. Duke Energy retains the right to amend, modify or terminate its benefits plans in any respect and at any time, and neither its benefits plans, nor your plan participation, will be considered a contract for future employment. For more information about applicable deductibles, coinsurance and plan limits, please call CVS Caremark Customer Service or visit ***www.Caremark.com****. For more detailed information on the Medical Plan, refer to the Duke Energy Active Medical Plan General Information Booklet and UnitedHealthcare® Benefits Booklet sections of this Summary Plan Description.*

The Duke Energy medical plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 888.465.1300. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888.465.1300. 注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：888.465.1300.

SECTION 7 – PRESCRIPTION DRUG BENEFIT SUMMARY

	CVS Caremark Retail Pharmacy Network For short-term medications (up to a 30-day supply) you pay:	**Maintenance Choice® CVS Caremark Mail Service Pharmacy or CVS Retail Pharmacy** For long-term medications (up to a 90-day supply) you pay:
Preventive Medications Includes certain contraceptive medications and routine vaccines	**$0**	**$0**
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**20%** of medication cost (after your deductible has been met)	**20%** of medication cost (after your deductible has been met)
Preferred Brand Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from the CVS Caremark Primary/Preferred Drug List.	**20%** of medication cost (after your deductible has been met)	**20%** of medication cost (after your deductible has been met)
Non-Preferred Brand Medications You will pay the most for medications not on the CVS Caremark Primary/Preferred Drug List.	**20%** of medication cost (after your deductible has been met)	**20%** of medication cost (after your deductible has been met)
Annual In-Network Deductible The deductible is a combined medical and prescription drug deductible.	$1,500 per year for individual coverage / $3,000* per year for family coverage	
Out-of-Pocket Maximum** The out-of-pocket maximum is a combined medical and prescription drug out-of-pocket maximum.	$3,500 per year for individual coverage / $7,000*** per year for family coverage	

*The deductible is a true family deductible. The full $3,000 amount must be reached before the Medical Plan pays any benefit for any covered member of the family (other than in-network benefits for certain preventive care services and preventive medications, including certain contraceptives and routine vaccines).

**Amounts you pay to satisfy the deductible and amounts you pay as co-insurance are applied toward your out-of-pocket maximum and are included for purposes of determining whether you have reached your out-of-pocket maximum.

***Not to exceed $6,850 for any one individual.

Maintenance Choice® is a registered mark of Caremark, LLC.

The Duke Energy medical plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 888.465.1300. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888.465.1300. 注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：888.465.1300.

DUKE ENERGY®

Active Medical Plan

PPO option

January 2018

This document replaces any documents previously issued which described your benefits.

Duke Energy Active Medical Plan
General Information

IMPORTANT NOTICE

This General Information booklet for the Duke Energy Active Medical Plan ("Medical Plan") provides information that is applicable to all Medical Plan coverage options. This booklet addresses eligibility for coverage under the Medical Plan, how to enroll, opportunities to make mid-year changes, when coverage ends and how you and your covered dependents may be able to continue coverage if it ends. It also contains information such as who provides coverage, who administers the Medical Plan, who decides claims for benefits, ERISA rights and Duke Energy Corporation's right to amend or terminate the Medical Plan.

The attached Medical Plan booklets and summaries of benefits describe your Medical Plan benefits, applicable deductible, co-pay and co-insurance information, how to submit a claim for Medical Plan benefits and other important information about your Medical Plan.

This General Information booklet, together with the Medical Plan booklets and summaries of benefits, is the Summary Plan Description (SPD) for the Medical Plan as of January 2018 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

TABLE OF CONTENTS

Page

Medical Coverage Availability

Duke Energy Corporation ("Duke Energy") offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (the "Claims Administrators"). The Medical Plan includes medical, surgical, hospitalization, prescription drug, wellness and disease management benefits.

There are various Medical Plan coverage options available, such as high-deductible health plan (HDHP) and preferred provider organization (PPO) options. If you do not have adequate access to network providers, you may qualify for an out-of-area (OOA) option. All of the Medical Plan options are designed to help you pay for health care expenses.

Duke Energy myHR™ Service Center

If you have any questions about the Medical Plan or the information in this General Information booklet, contact the Duke Energy myHR Service Center at 1-888-465-1300. Information also is available through the *Your Benefits Resources*™ (YBR) website at http://resources.hewitt.com/duke-energy.

Eligibility

Eligible Employees

Generally, you are eligible for coverage under the Medical Plan on your first day of active work as an eligible employee (provided you enroll within 31 calendar days of the date you become an eligible employee).

To be an eligible employee, you must be identified in and paid through Duke Energy's payroll system as an employee of Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan (individually or collectively referred to with Duke Energy as the "Company," as appropriate) and you must be classified by your Company as a:

- regular employee; or
- fixed-term employee.

Generally, you are a regular employee if you fill a regular position that is typically longer than 180 days in duration, and you are a fixed-term employee if you are hired for a position for a specifically defined time frame, duration of a project (usually one year or less), until services are no longer needed, or until the work goes away.

You are not eligible to participate in the Medical Plan if you are:

- a non-resident alien with no U.S. source income;
- not on a U.S. payroll of the Company;
- covered by a collective bargaining agreement, unless the collective bargaining agreement in effect expressly provides for participation in the Medical Plan (a copy of your applicable collective bargaining agreement can be obtained from your union steward, union hall, Duke Energy Labor Relations contact or immediate supervisor);

- an individual who has waived eligibility through any means, including an individual whose employment is governed by a written agreement (including an offer letter setting forth terms and conditions of employment) that provides the individual is not eligible for benefits (a general statement in the agreement, offer letter or other communication stating that the individual is not eligible for benefits is construed to mean that the individual is not eligible to participate in the Medical Plan); or
- a temporary employee, a seasonal employee or any other employee who is not a regular employee or fixed-term employee.

In some circumstances, an individual who provides services to the Company under an agreement that identifies the individual as an independent contractor or through a third party (such as a contracting services firm, temporary agency or leasing organization) may be considered a Company "employee" for certain purposes under the law, such as tax withholding. Such an individual is not paid through the Company's payroll system and is not eligible for the Medical Plan.

Eligible Dependents

When you enroll for certain coverage, you may elect to cover your eligible dependents, which may include:

- your eligible spouse
- your eligible domestic partner
- your eligible child(ren)

Spouse Eligibility

Your spouse, eligible for coverage as a dependent, is a person to whom you are legally married under applicable law, which may include "common law marriage" and "same-sex marriage."

Generally, for health coverage of a taxpayer's spouse to be tax-free to the taxpayer, the spouse must be recognized as such under applicable state law and any related federal guidance, which may include "common law marriage" and "same-sex marriage."

By enrolling your spouse in the Medical Plan, you are affirmatively representing that your spouse is eligible for coverage under the Medical Plan. Failure to drop your spouse from coverage constitutes a continuous affirmation of your spouse's eligibility.

You must immediately report any spouse who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your spouse's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible spouse, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your spouse after your spouse ceases to be eligible will be considered a misrepresentation of your spouse's eligibility.

Domestic Partner Eligibility

If you are enrolled in Medical Plan coverage, you can elect coverage for your eligible same- or opposite-sex domestic partner. You and your domestic partner must continuously:

- be each other's sole domestic partner, and intend to remain so indefinitely;
- be at least 18 years of age and mentally competent to enter into a legal contract;
- have lived together in a common household for the immediately preceding 6 consecutive months;
- share financial obligations of, and be jointly responsible for, the common household;
- not be legally married to or legally separated from anyone else, nor in a domestic partnership with anyone else; and
- not be related by blood or marriage to a degree of closeness that would prohibit marriage to one another in your current state of residence.

By enrolling your domestic partner in the Medical Plan, you are affirmatively representing that your domestic partner is eligible for coverage under the Medical Plan. Failure to drop your domestic partner from coverage constitutes a continuous affirmation of your domestic partner's eligibility.

You must immediately report any domestic partner who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your domestic partner's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible domestic partner, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your domestic partner after your domestic partner ceases to be eligible will be considered a misrepresentation of your domestic partner's eligibility.

Child Eligibility

Your child is:

- your biological child, up to age 26; **or**
- your legally adopted child, including a child placed in your home for legal adoption by you as long as the child remains in your home and the adoption procedure has not been terminated, and whether or not the adoption has become final, up to age 26; **or**
- your stepchild, up to age 26; **or**
- your foster child, up to age 26; **or**
- your domestic partner's biological child, legally adopted child (including a child placed in your home for legal adoption by your domestic partner as long as the child remains in your home and the adoption procedure has not been terminated, whether or not the adoption has become final), stepchild or foster child, who is primarily dependent on you for support, whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26; **or**
- any other child for whom you, your spouse or your domestic partner has legal guardianship, full or joint legal custody or managing conservatorship under a valid court decree, who is primarily dependent on you for support, whom you claim as a dependent

for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26.

In addition, your child may be covered at any age if:

- he or she became physically or mentally incapable of self-support while enrolled in a Company-sponsored medical plan and before reaching the applicable limiting age of 26 and continuously remains incapacitated and enrolled in a Company-sponsored medical plan; **or**
- he or she was physically or mentally incapable of self-support on your date of employment with the Company, was enrolled in a Company-sponsored medical plan as of your employment date and continuously remains incapacitated and enrolled in a Company-sponsored medical plan.

By enrolling a dependent child in the Medical Plan, you are affirmatively representing that the child is eligible for coverage under the Medical Plan. Failure to drop your child from coverage constitutes a continuous affirmation of your child's eligibility.

You must immediately report any dependent child who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your dependent child's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible dependent child, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your child after your child ceases to be eligible will be considered a misrepresentation of your child's eligibility.

An eligible child only can be covered by one Company employee or retiree.

Surviving Spouse, Domestic Partner and Child Eligibility

If you die while you and your spouse/domestic partner are covered under the Medical Plan, your surviving spouse/domestic partner may continue Medical Plan coverage by making contribution payment arrangements with the Duke Energy myHR Service Center. This coverage can be continued until the earliest of your spouse's remarriage, your domestic partner's establishment of a new domestic partner relationship, the death of your spouse/domestic partner and the date that your spouse/domestic partner becomes eligible for other coverage (e.g., through an employer's plan or Medicare).

If you are survived by dependent children, their medical coverage may continue for as long as they:

- continue to meet the definition of eligible dependents; and
- make required payments for coverage. Payment arrangements should be coordinated with the Duke Energy myHR Service Center.

This provision applies even if your spouse/domestic partner dies or loses coverage after you.

Your surviving spouse/domestic partner and/or dependent children will be charged for their component of the contribution for coverage. If coverage under the Medical Plan is declined or

ends, your covered dependents may be eligible for continued coverage under COBRA for up to 36 months in certain situations.

Your spouse/domestic partner must immediately report any dependents who should be dropped from survivor coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your dependent's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for ineligible dependents, your spouse/domestic partner should contact the Duke Energy myHR Service Center. Any failure to drop coverage for a dependent after the dependent ceases to be eligible will be considered a misrepresentation of the dependent's eligibility.

See *Termination of Coverage for Non-Payment* for a description of what happens when required payments for coverage are not made.

If you are covered under the Medical Plan and your spouse/domestic partner is an eligible retiree who is covered as your dependent, your spouse/domestic partner may elect retiree coverage under the Duke Energy Retiree Medical Plan or individual coverage through an insurance exchange at the time of your death if your spouse/domestic partner has not reached age 65 at the time of your death, or may be able to elect individual coverage through a Medicare exchange if your spouse/domestic partner is age 65 or older at the time of your death.

Employee and Retiree Couples

No one may be considered as a dependent of more than one employee or more than one retiree.

Verification of Dependent Status

By enrolling your dependent in the Medical Plan, you are affirmatively representing that your dependent is eligible for coverage under the Medical Plan. You will be required to provide evidence of dependent eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order, adoption papers or proof of joint residency within 30 calendar days following the date of enrollment. If you fail to provide proper evidence of dependent eligibility in a timely manner, coverage for your dependent generally will end 45 calendar days following the date of enrollment. See *Claims Determination Procedures* for a description of how to file an eligibility or enrollment claim if your dependent's Medical Plan coverage ends due to a failure to timely provide evidence of dependent eligibility. If your claim or appeal is granted, coverage for your dependent may be reinstated retroactively to the date coverage for your dependent was dropped.

To continue coverage beyond age 26 for a child who is physically or mentally incapable of self-support, you must provide evidence of your child's incapacity to the Medical Plan Claims Administrator. The application can be obtained by contacting the Duke Energy myHR Service Center. You may be required periodically to provide evidence of the child's continuing incapacity.

If a Dependent Becomes Ineligible

If a covered spouse, domestic partner or dependent child becomes ineligible for coverage during the year (for example, if your child reaches age 26), the individual(s) who become(s) ineligible for coverage will be dropped from your coverage.

You must immediately report any dependents who should be dropped from coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. When you report a dependent's loss of eligibility within 31 calendar days of the loss of eligibility:

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage; and

- changes to your contribution amounts will be made as soon as administratively practicable after the date on which you notify the Duke Energy myHR Service Center that your dependent is no longer eligible.

If you do not inform the Duke Energy myHR Service Center of a covered dependent's ineligibility within 31 calendar days of the loss of eligibility:

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage;

- no changes to your coverage level, if applicable, may be made until the next annual enrollment period or, if earlier, the date you experience another work/life event which allows you to change your Medical Plan election (this means that you must continue to pay for the dependent's coverage through the end of the year in which the dependent loses eligibility for coverage even though he or she is no longer covered, unless you experience another work/life event which allows you to change your Medical Plan election);

- the coverage provided while your dependent is ineligible will be considered as part of the individual's COBRA coverage period (this period begins on the first day of the month following the month in which eligibility is lost); and

- COBRA contributions (102% of the total cost) will be required to pay for the coverage received since the end of the month in which eligibility was lost if the individual elects continuation of coverage under COBRA.

To drop coverage for ineligible dependents, contact the Duke Energy myHR Service Center.

The Company reserves the right to seek recovery of any benefits paid under the Medical Plan to your ineligible dependents.

Enrolling in the Medical Plan

When You Are First Eligible

When you are eligible to enroll, you will make your Medical Plan election using an online enrollment tool. You will receive additional information about the online enrollment tool when you become eligible.

If you have questions or need assistance in making your Medical Plan election, contact the Duke Energy myHR Service Center.

When you enroll in the Medical Plan as an eligible employee, based on the dependent(s) that you elect to cover, if any, your coverage level will be one of the following:

- Individual Only
- Individual + Spouse/Domestic Partner
- Individual + Child(ren)
- Individual + Family (Spouse/Domestic Partner and Child(ren))

You must make your election within 31 calendar days of becoming eligible for coverage in order for coverage to begin on the date you become an eligible employee. If you do not make your election within 31 calendar days of becoming eligible, your next opportunity to enroll will be during a subsequent annual enrollment period or within 31 calendar days of a work/life event for which mid-year changes are allowed.

By accessing the enrollment tool or calling the Duke Energy myHR Service Center and making your coverage election when you are first eligible, you are affirmatively representing that all information provided during enrollment including, but not limited to, the eligibility of any dependents for coverage and/or your non-tobacco user status (and that of your spouse/domestic partner, as applicable) is true and correct. If Duke Energy discovers that any information you provide during enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

You also may decline coverage altogether.

During Annual Enrollment

Each fall you will have the opportunity to change your Medical Plan election for the following plan year, including changing your coverage option or electing to drop or add eligible dependents. This process is referred to as "annual enrollment." You will receive information and instructions each fall about annual enrollment.

By accessing the enrollment tool or calling the Duke Energy myHR Service Center and making (or not changing, as applicable) your coverage election during annual enrollment, you are affirmatively representing that all information provided during annual enrollment including, but not limited to, the eligibility of any dependents for coverage, your completion of any wellness program initiatives and/or your non-tobacco user status (and that of your spouse/domestic partner, as applicable) is true and correct. If Duke Energy discovers that any information you provide during annual enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

Other Opportunities to Enroll

Under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you can enroll yourself and your eligible dependents for coverage under the Medical Plan during the year if:

- you or your dependent had other coverage under another health plan or health insurance at the time the Medical Plan was previously offered to you; and
- you did not enroll in the Medical Plan; and
- you or your dependents lose such other coverage and are otherwise eligible for coverage under the Medical Plan.

To enroll for Medical Plan coverage in such a circumstance, the following conditions must be satisfied:

- The other coverage was:
  - Under a federal continuation provision (COBRA) and the continuation period for the other coverage was exhausted. (COBRA coverage is considered exhausted when it ceases for any reason other than either failure of the individuals to pay contributions on a timely basis or for cause (fraudulent or intentional misrepresentation).)
  - Not under COBRA and the other coverage terminated as a result of (1) loss of eligibility (such as loss of eligibility due to legal separation, divorce, death, termination of employment or reduction in the number of hours of employment), or (2) employer contributions toward the other coverage end.

In any case, the other coverage must not have terminated because you failed to pay timely contributions, or for cause (such as filing fraudulent claims).

HIPAA also allows you to enroll yourself, your eligible spouse and/or your newly eligible child if you acquire an eligible dependent through marriage, birth, adoption or placement for adoption.

If you need to enroll for coverage under the Medical Plan as a result of one of these events (such as loss of other coverage, or because you acquire an eligible dependent through marriage, birth, adoption or placement for adoption) you must enroll within 31 calendar days of the event. Otherwise, unless a subsequent work/life event giving rise to a mid-year change occurs (see *Mid-Year Changes*), you must wait until the next annual enrollment.

HIPAA also allows you to enroll yourself and your eligible dependents for coverage under the Medical Plan during the year if:

- you or your eligible dependents lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you or your eligible dependents, as applicable, are no longer eligible; or
- you or your eligible dependents become eligible for premium assistance under a Medical Plan option through a state's premium assistance program under Medicaid or CHIP.

If you need to enroll for coverage under the Medical Plan as a result of one of these two events, you must enroll within 60 calendar days of the event. Otherwise, unless a subsequent work/life event giving rise to a mid-year change occurs (see *Mid-Year Changes),* you must wait until the next annual enrollment.

If You Are Rehired

If your Medical Plan coverage ends due to your termination of employment with the Company or layoff and you are reemployed by the Company as an active employee within 31 calendar days

and within the same plan year, you will be automatically reenrolled in the Medical Plan (in the previous coverage option and at the previous coverage level). If you have experienced a work/life event for which you can make a change in your Medical Plan election (such as marriage, divorce or birth), you can add and/or drop coverage for your eligible dependent(s), as applicable, within 31 calendar days of the date you again become an eligible employee. If you are reemployed more than 31 calendar days after your termination or in a subsequent plan year, you must reenroll as a new employee.

If you retire from the Company as an eligible retiree and are later rehired as an eligible active employee, you will be eligible for coverage as an active employee. When your employment subsequently terminates, you may be able to reelect retiree coverage under the Duke Energy Retiree Medical Plan or individual coverage through an insurance exchange if you are not yet age 65 at that time, or you may be able to elect individual coverage through a Medicare exchange if you are age 65 or older at that time.

Cost of Coverage

You and the Company share in the cost of medical coverage for yourself and your covered dependents. Your contribution amount is based on the Medical Plan coverage option that you elect and the eligible dependent(s) you choose to cover. Information about contribution amounts is available through the YBR website.

Your contributions for medical coverage while an employee are deducted from your pay on a pre-tax basis each pay period. Because your contributions are taken as deductions on a pre-tax basis, they are not subject to federal income, Social Security and most states' income taxes.

Even though you reduce your income for tax purposes through pre-tax contributions for medical coverage, you are not reducing the value of your other Company pay-related benefits, such as life insurance, disability insurance and retirement benefits. These benefits are based on your pay before contributions for medical coverage are deducted.

If you elect coverage for a domestic partner, the portion of your contribution required to cover the domestic partner under the Medical Plan is deducted on a pre-tax basis. On pay advice statements, the value of the coverage associated with the benefits you elected under the Medical Plan for your domestic partner will appear as imputed income and is subject to applicable taxes. Please note that the Company does not provide tax advice, and you should consult with your tax advisor for information about the tax consequences of electing coverage for a domestic partner.

Live Well Incentive Program

Under the Duke Energy *Live Well* Incentive Program (the "*Live Well* Program"), you and your spouse/domestic partner may be eligible to earn rewards that will be applied to reduce your contributions for coverage under the Medical Plan during the following calendar year. For example, if you complete a Biometric Screening under the *Live Well* Program during an applicable year's program cycle, or if your spouse/domestic partner completes a Health Survey under the *Live Well* Program during an applicable year's program cycle, the rewards you and your spouse/domestic partner earn for completing these activities may be applied to reduce your contributions for medical coverage each pay period throughout the following year on a pro-rated basis (i.e., applied evenly to reduce the contribution you make toward the cost of medical coverage each payroll period during the following year).

Employee Eligibility

You are eligible to earn rewards under the *Live Well* Program if you are a U.S.-based active employee who is eligible for the Medical Plan or if you are a U.S.-based employee on an approved paid leave of absence who is eligible for the Medical Plan, whether or not you are enrolled in the Medical Plan. However, you are not eligible to earn rewards under the *Live Well* Program if you are approved for an unpaid leave of absence or long-term disability benefits under a Duke Energy-sponsored long-term disability plan.

Any rewards you earn under the *Live Well* Program will generally be applied to reduce your contributions for coverage under the Medical Plan during the following calendar year. However, if you do not enroll in the Medical Plan for a calendar year, or you are an employee who will be covered under the Medical Plan in a calendar year as a dependent of another Company employee, your *Live Well* Program rewards earned during an applicable year's program cycle will be paid in cash (less applicable taxes) on a prorated basis in your paycheck each pay period during the following calendar year.

There are instances in which you may not receive the *Live Well* Program rewards you have earned, as described below.

- If you are not enrolled in the Medical Plan while you are on an unpaid leave of absence or receiving long-term disability benefits under a Duke Energy-sponsored long-term disability plan, you will not receive any rewards that you earned during the prior year's program cycle that have not been redeemed when your leave of absence or long-term disability benefits commence. You will receive the rewards that you earned during the prior year's program cycle only if you return to active employment during the calendar year following the year in which you earned your rewards, in which case your remaining rewards will be paid to you in cash (less applicable taxes) on a prorated basis in your paycheck during the remaining pay periods in that calendar year.

- If you terminate your employment during a calendar year, you will not receive the rewards that you earned during the prior year's program cycle that have not been redeemed as of your termination date.

- You will not receive the rewards that you earned during the prior year's program cycle that have not been redeemed as of the date you cease to be eligible for the Medical Plan.

Spouse/Domestic Partner Eligibility

Your spouse/domestic partner is eligible to participate in the *Live Well* Program only if you are eligible to participate in the *Live Well* Program as described above, and your spouse/domestic partner is actually enrolled in the Medical Plan. If you are not eligible to participate in the *Live Well* Program, your spouse/domestic partner is not eligible to participate in the *Live Well* Program either, even if your spouse/domestic partner is actually enrolled in the Medical Plan.

If your spouse/domestic partner does not enroll in the Medical Plan for a calendar year, neither you nor your spouse/domestic partner will receive *Live Well* Program rewards your spouse/domestic partner earned during the preceding year's program cycle. This means that your spouse's/domestic partner's *Live Well* Program rewards earned during the preceding year's program cycle will not be used to reduce your contributions for medical coverage throughout the calendar year and will not be paid to you or your spouse/domestic partner in cash.

Live Well Program Activities and Rewards

The activities that you and/or your spouse/domestic partner must complete to receive *Live Well* Program rewards may vary with each program cycle. Review the *Live Well* Program materials sent to you prior to the beginning of each calendar year for additional information on the upcoming program cycle's activities and requirements.

The Medical Plan is committed to helping you achieve your best health. Rewards for participating in the *Live Well* Program are available to all employees who are eligible to participate in the Medical Plan, regardless of Medical Plan enrollment. If you think you might be unable to complete an activity required for you to receive a reward under the *Live Well* Program, you might qualify for an opportunity to earn the same reward by different means. Contact Health and Wellness Portal Support at 1-877-818-5826 and a representative will work with you (and, if you wish, your doctor) to find an activity with the same reward that is right for you in light of your health status.

Non-Tobacco User Discount

A non-tobacco user discount also is available to reduce the cost of coverage under the Medical Plan coverage options. To qualify for the applicable non-tobacco user discount, you (and your spouse/domestic partner) must:

- be tobacco free (including smokeless tobacco and electronic cigarettes);
- have been tobacco-free (including smokeless tobacco and electronic cigarettes) during the 12 months preceding the effective date of your coverage (or during such other period as may be communicated to you in your annual enrollment materials); and
- remain tobacco free (including smokeless tobacco and electronic cigarettes) during the coverage period.

In order to receive the non-tobacco user discount for you and/or your spouse/domestic partner you must complete:

- a non-tobacco user attestation ("Attestation") when you enroll in the Medical Plan using the online enrollment tool or through the Duke Energy myHR Service Center, and
- if you attest to being a tobacco user, the Alternate Procedure Certification described below by the specified deadline.[1]

If you do not complete the Attestation during enrollment, or, if you complete the Attestation and attest to being a tobacco user but you do not complete the Alternate Procedure Certification described below by the applicable deadline, you (and your spouse/domestic partner) will not receive the non-tobacco user discount for Medical Plan coverage. Tobacco user status does not carry over from year to year for Medical Plan coverage.

[1]We will work with you (and/or your spouse/domestic partner) and, if you wish, with your doctor and/or your spouse's/domestic partner's doctor, prior to the Alternate Procedure Certification submission deadline, to find an alternate procedure that provides the same non-tobacco user discount that is right for you (and/or your spouse/domestic partner) in light of your (and/or your spouse's/domestic partner's) health status.

By completing the Attestation in the online enrollment tool or through the Duke Energy myHR Service Center, you are affirmatively representing your (and your spouse's/domestic partner's) tobacco user status and if you (and your spouse/domestic partner) are tobacco-free, your eligibility for the non-tobacco user discount under the Medical Plan. If you complete the Attestation as a non-tobacco user during enrollment and you (or your spouse/domestic partner) become a tobacco user during the period of coverage, you must notify the Duke Energy myHR Service Center within 31 calendar days of the date that you (or your spouse/domestic partner) become a tobacco user. Changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice.

If you misrepresent your tobacco user status (or the tobacco user status of your spouse/domestic partner) in the Attestation, or if you (or your spouse/domestic partner) become a tobacco user after completing the Attestation as a non-tobacco user and you do not notify the Duke Energy myHR Service Center of the change in tobacco user status, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of Medical Plan coverage and/or discharge, and to take other appropriate action.

Non-Tobacco User Discount – Alternate Procedure for Active Employees

The Medical Plan is committed to helping you (and your spouse/domestic partner) achieve your best health. The non-tobacco user discount is available to all covered employees (and their covered spouses/domestic partners). If you (and/or your covered spouse/domestic partner) do not qualify for the non-tobacco user discount because you are not currently tobacco free, have not been tobacco free for the 12 months preceding the effective date of your coverage (or during such other period as may be communicated to you in your annual enrollment materials) or intend to use tobacco during the coverage period, you may still qualify for the discount if you satisfy one of the following requirements.

- If you are enrolling as a newly eligible employee (and/or a newly eligible spouse/domestic partner), you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - enroll in the Quit for Life Tobacco Cessation Program (the "Quit for Life Program") within 31 days of the date you enroll in your benefits, and
    - properly complete and submit a written Alternate Procedure Certification within 31 days of the date you (and/or your spouse/domestic partner) enroll in your benefits certifying that you (and/or your spouse/domestic partner) have enrolled in the Quit for Life Program and that you (and/or your spouse/domestic partner) will complete the Quit for Life Program within seven months of enrolling in the Quit for Life Program[2] – or –

[2] If you (and/or your covered spouse/domestic partner) enrolled in the Quit for Life Program and you properly completed and submitted the Alternate Procedure Certification within 31 days of the date you (and/or your spouse/domestic partner) enrolled in your benefits, but you (and/or your spouse/domestic partner) have not yet reached your seven month completion deadline for the Quit for Life Program by annual enrollment, you may qualify for the non-tobacco user discount if you properly complete and submit a written Alternate Procedure Certification during annual enrollment on or before the communicated deadline stating that you (and/or your spouse/domestic partner) enrolled in the Quit for Life Program on or before the communicated deadline and that you (and/or your spouse/domestic partner) will complete the

- If you are enrolling during annual enrollment, you must:
    - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
    - enroll in the Quit for Life Program on or before the communicated deadline, and
    - properly complete and submit an Alternate Procedure Certification on or before the communicated deadline certifying that you (and/or your spouse/domestic partner) enrolled in the Quit for Life Program on or before the communicated deadline and that you (and/or your spouse/domestic partner) will complete the Quit for Life Program on or before the following June 30.

The Alternate Procedure Certification is found on the Duke Energy Portal. You may contact the Duke Energy myHR Service Center to discuss remitting the information required under the alternate procedure. You will not receive the non-tobacco user discount until your Alternate Procedure Certification has been approved, at which time the non-tobacco user discount will be applied on a prospective basis as soon as administratively practicable.

To enroll in the Quit for Life Program, contact Quit for Life at 1-866-784-8454. You (and/or your spouse/domestic partner) will not be required to pay for the cost of the Quit for Life Program. Please note that the Quit for Life Program takes up to six months to complete. You can begin the Quit for Life Program as soon as you enroll. After your (and/or your spouse's/domestic partner's) initial year of claiming the discount in accordance with this procedure, in order to continue the non-tobacco user discount under the alternate procedure in any future year, a new Alternate Procedure Certification will be required.

If You Do Not Successfully Complete the Alternate Procedure

Duke Energy will audit your (and/or your spouse's/domestic partner's) completion of the Alternate Procedure (including completion of the Quit for Life Program). If you (or your spouse/domestic partner) certify that you will complete the Quit for Life Program and you (and/or your spouse/domestic partner) do not complete the Quit for Life Program by the deadline indicated in the alternate procedure, you must notify the Duke Energy myHR Service Center within 31 calendar days of the date that you (or your spouse/domestic partner) fail to meet the deadline. Changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice or, if earlier, the date that the Company learns of such failure.

If You Misrepresent Information in the Alternate Procedure Certification

If you misrepresent any information in your Alternate Procedure Certification, including, but not limited to, your enrollment in the Quit for Life Program, or if you do not complete the Quit for Life Program by the applicable deadline, Duke Energy reserves the right to recover any contribution amounts you should have paid, to take appropriate disciplinary action for falsification of documents, up to and including termination of health and insurance coverage and/or discharge, and to take other appropriate action.

Quit for Life Program by the original completion date of seven months after your initial enrollment in the Quit for Life Program.

Termination of Coverage for Non-Payment

Your coverage will be terminated for non-payment if:

- you do not make the required payment in full for two months; or
- you call the Duke Energy myHR Service Center to indicate the payment is being sent, but it does not arrive by the due date.

If your coverage is terminated for non-payment, you will receive a Confirmation of Coverage statement indicating that your coverage has been cancelled.

Except in cases of termination of COBRA coverage for non-payment, reinstatement after non-payment is possible if you contact the Duke Energy myHR Service Center no later than three months from the date printed on the Confirmation of Coverage statement. However, past due contributions must be paid in full to reinstate coverage. Reinstatement after non-payment will be allowed only one time. If COBRA coverage is terminated for non-payment, reinstatement is not available. Any amounts owed in arrears at the time of a death or coverage change will continue to be billed and must be paid.

When Coverage and Contributions Begin

When you make your Medical Plan election as a newly eligible employee, coverage begins on the date you become eligible (assuming that you make your election within 31 calendar days of becoming eligible). Deductions for your contributions begin as soon as administratively practicable following the date that you make your election.

When you make your coverage elections during annual enrollment, coverage begins on January 1 of the following calendar year. Deductions for your contributions begin the first pay period of the following calendar year.

Mid-Year Changes

Once you have made your Medical Plan election for the year, you may not change it during that year unless you have a work or life event for which a mid-year election change is permitted and the work or life event results in the gain or loss of eligibility for coverage. Specific information about these "work/life" events and allowable mid-year election changes is available through the YBR website located on the Duke Energy Portal or by contacting the Duke Energy myHR Service Center. A "mid-year election change" refers to any change made to your coverage during a calendar year due to a work or life event that results in the gain or loss of eligibility for coverage.

If you experience a work/life event for which mid-year election changes are allowed, you have 31 calendar days from the date of the event (for example, your marriage date) to change your election. Otherwise, unless a subsequent work/life event giving rise to a mid-year election change occurs, you cannot change your Medical Plan election until annual enrollment.

If you are eligible to make changes, the election you make must be consistent with and on account of the work/life event.

Below is a list of some work/life events for which mid-year election changes are allowed:

- Your legal marital status changes
  - you get married
  - you get divorced or have your marriage annulled
  - you get legally separated and lose coverage under your spouse's employer plan
  - your spouse dies
- Your domestic partner status changes
  - your domestic partner becomes eligible for coverage
  - your domestic partner relationship ends
  - your domestic partner dies
- The number of your eligible children changes
  - you have, or adopt, a child
  - you become the legal guardian of a child
  - your child gains or loses eligibility for coverage under the Medical Plan (for example, your dependent child reaches age 26)
  - a Qualified Medical Child Support Order (QMCSO) is received[3]
  - your child dies
- Your dependent's benefits coverage changes because:
  - he or she gains or loses coverage due to a change in eligibility as a result of a change in employment status or work schedule
  - his or her period of coverage and annual enrollment window is different from yours
- Your or your dependent's COBRA coverage from another employer expires
- You enroll in a qualified health plan through a federal or state Marketplace during the Marketplace's annual enrollment period or during a special enrollment period available in the Marketplace
- You or your dependent becomes entitled to or loses Medicare or Medicaid[4]
- You or your dependent loses or gains coverage under a group health plan
- There is a significant increase or decrease in the cost of coverage under the employer plan in which your dependent participates
- You die

[3] If a Qualified Medical Child Support Order is issued requiring medical coverage for your child, you may change your medical coverage election to provide coverage for your child. You also may make an election change to cancel medical coverage for the child if the order requires the child's other parent to provide coverage.

[4] Entitlement to Medicare or Medicaid. If you, your spouse or any dependent child is enrolled in the Medical Plan and subsequently become entitled to coverage in Part A or Part B of Medicare or in Medicaid, you may make an election to cancel Medical Plan coverage for that individual.

When Your Dependent Is No Longer Eligible

If a covered dependent ceases to be eligible for benefits, your dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage. If you notify the Duke Energy myHR Service Center within 31 calendar days of the loss of eligibility, changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice. See *If a Dependent Becomes Ineligible* for information about the consequences of failing to notify the Duke Energy myHR Service Center within 31 calendar days of a loss of eligibility.

When You Enroll a Dependent Mid-Year

If your change is to add a dependent to your Medical Plan coverage, and your dependent's eligibility for Medical Plan coverage has not previously been verified, you will be required to provide evidence of dependent eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order, adoption papers or proof of joint residency within 30 calendar days following the date of enrollment. If you fail to provide proper evidence of dependent eligibility in a timely manner, coverage for your dependent generally will end 45 calendar days following the date of enrollment. See *Claims Determination Procedures* for a description of how to file an eligibility or enrollment claim if your dependent's Medical Plan coverage ends due to a failure to timely provide evidence of dependent eligibility. If your claim or appeal is granted, coverage for your dependent may be reinstated retroactively to the date coverage for your dependent was dropped.

When Mid-Year Coverage and Contribution Changes Are Effective

This section outlines the timing of coverage and contribution changes when you (i) elect to start or increase coverage due to a work/life event, (ii) elect to decrease or terminate coverage due to a work/life event or (iii) stop or decrease coverage due to a covered individual becoming ineligible for coverage (e.g., divorce or child reaches age 26).

- **Start or Increase Coverage**. If you elect to start or increase your coverage due to a work/life event, your coverage changes on the day the work/life event occurred. In order for the change to take effect on the day the work/life event occurred, you must notify the Duke Energy myHR Service Center within 31 calendar days of the work/life event. Changes to your contribution amounts are effective as soon as administratively practicable after you submit your election changes.

- **Elective Decrease or Termination of Coverage**. If you elect to decrease or terminate coverage due to a work/life event, your coverage changes on the first day of the month after you submit your election changes. You must notify the Duke Energy myHR Service Center within 31 calendar days of the work/life event in order for the change to become effective on the first day of the month after you submit your election changes. Changes to your contribution amounts are effective as soon as administratively practicable after you submit your election changes.

- **Decrease or Termination of Coverage Due to Loss of Eligibility**. Coverage for individuals who are no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage. Changes to your contribution amounts generally are effective as soon as administratively practicable after you submit your

election changes provided that you notify the Duke Energy myHR Service Center within 31 days of the loss of eligibility. See *If a Dependent Becomes Ineligible* above for the consequences of failing to notify the Duke Energy myHR Service Center of a covered individual's ineligibility within 31 calendar days of the loss of eligibility. Note that in the event of your death, coverage for you and your dependents ends on the date of your death. See *Surviving Spouse, Domestic Partner and Child Eligibility* above for information about coverage available to your spouse/domestic partner and/or child if you die while they are covered under the Medical Plan.

Situations Impacting Your Eligibility for Coverage

If You Are on an Authorized Leave of Absence

While you are on an authorized leave of absence, you may be eligible to continue your coverage under the Medical Plan. Contact the Duke Energy myHR Service Center for additional information regarding your ability to continue coverage under the Medical Plan during an authorized leave of absence. If your authorized leave of absence is unpaid such that you begin to be billed directly for the monthly contribution for your medical coverage, see *Termination of Coverage for Non-Payment* for a description of what happens when required payments for coverage are not made.

If You Become Disabled

If you begin receiving disability benefits under the Duke Energy Short Term Disability Plan or the Duke Energy Long Term Disability Plan, you may be eligible for continued coverage under the Medical Plan. Contact the Duke Energy myHR Service Center for additional information regarding your ability to continue coverage under the Medical Plan if you begin receiving disability benefits. If you begin to be billed directly for the monthly contribution for your medical coverage, see *Termination of Coverage for Non-Payment* for a description of what happens when required payments for coverage are not made.

When You Reach Age 65

If you continue to work past age 65, Medical Plan coverage for you and your covered dependents will continue as long as you remain an eligible employee, your covered dependents remain eligible dependents and you pay any required contributions. If you continue to work past age 65, your Medical Plan coverage will be primary to Medicare for you and any covered dependents over age 65, except in certain situations related to an end stage renal disease diagnosis.

If You Become Entitled to Medicare

If you are "not actively at work" and you become entitled to Medicare, you can elect to continue your coverage under the Medical Plan or enroll in individual coverage through a Medicare exchange. If you wish to continue your enrollment in Duke Energy-sponsored coverage, you will be required to enroll in a Medical Plan option that coordinates with Medicare Part B (note that there is no coordination of benefits between the Medical Plan's prescription drug coverage and Medicare Part D). For these purposes, you are considered to be "not actively at work" if you are not actively working as an employee or you have been receiving long-term disability benefits for six months or longer. Contact the Duke Energy myHR Service Center for additional information regarding the options available to you when you become entitled to Medicare.

If you elect to terminate your coverage under the Medical Plan when you become entitled to Medicare, any of your eligible dependents who are covered under the Medical Plan and are not eligible for Medicare may continue coverage under the Medical Plan until reaching age 65.

If you are "not actively at work" because you have been receiving long-term disability benefits for six months or longer and you and/or a covered dependent enroll in a Medicare prescription drug plan for a calendar year, you and/or your covered dependent will not be eligible for coverage under the Medical Plan for that calendar year. Therefore, Medical Plan coverage ends for a calendar year for individuals who enroll in a Medicare prescription drug plan mid-year. Such individuals may be able to enroll for Medical Plan coverage at the next annual enrollment if Medicare prescription drug coverage is dropped for the following calendar year.

Termination of Coverage

When Coverage Ends

Your coverage under the Medical Plan will cease on the earliest of the following dates:

- the last day of the month in which your employment ends, unless you elect to continue coverage under COBRA;
- the last day of the month in which you cease to be an eligible employee or dependent or otherwise cease to be eligible for coverage under the Medical Plan;
- the last day of the month in which a work stoppage begins;
- the end of the period for which your last required contribution was made;
- the date of your death; or
- the date the Medical Plan is discontinued.

Your dependent's coverage will end when your coverage ends, at the end of the period for which your last required contribution was made, on the last day of the month in which you elect not to cover the dependent, or on the last day of the month in which the dependent loses eligibility, unless he or she continues his or her coverage under COBRA or through survivor coverage, as applicable. Medical Plan coverage actually will terminate, but it will be reinstated retroactive to the coverage termination date if the COBRA enrollment is properly received and processed. COBRA enrollment forms must be completed and received within 60 days of the event or notification, whichever is later.

If You Become Divorced or Your Domestic Partner Relationship Ends

If you cover a spouse/domestic partner under the Medical Plan and you become divorced or your domestic partner relationship ends, you must drop coverage for your former spouse/domestic partner within 31 calendar days of the divorce or the date on which your domestic partner relationship ends. Your former spouse/domestic partner will then be notified that he or she may continue coverage through COBRA by contacting the COBRA administrator within 60 days of the qualifying event.

See *If a Dependent Becomes Ineligible* for a description of what happens when you either do or do not report your divorce or the end of your domestic partner relationship within 31 calendar days.

To drop coverage for your former spouse/domestic partner, contact the Duke Energy myHR Service Center.

If You Leave the Company

If your employment with the Company terminates, your coverage under the Medical Plan will end on the last day of the month in which your employment terminates, unless you elect to continue coverage under COBRA.

See *If You Are Rehired* for a description of what happens if you are reemployed by the Company after your termination of employment.

If You Retire

If you are an eligible retiree, you may elect retiree coverage under the Duke Energy Retiree Medical Plan or individual coverage through an insurance exchange if you have not reached age 65 when you retire, or individual coverage through a Medicare exchange if you are age 65 or older when you retire. Additional information about your coverage options will be provided to you when you retire.

COBRA Continuation Coverage

Under COBRA (Consolidated Omnibus Budget Reconciliation Act), you, your spouse and eligible dependent children may elect to continue Medical Plan coverage if certain qualifying events occur. Although domestic partners are not entitled to continuation coverage under COBRA, the Company will apply the same rules to a domestic partner as to a spouse.

There also may be other coverage options available to you and your family if you experience a qualifying event. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace.

Continued Coverage for You

You may continue coverage for yourself and your covered eligible dependents under the Medical Plan for up to 18 months if you lose coverage under the Medical Plan due to:

- termination of your employment (for reasons other than gross misconduct); or
- a reduction of your work hours.

Continued Coverage for Your Dependents

Your covered dependents may continue their coverage under the Medical Plan for up to 36 months if they lose coverage as a result of your:

- death;
- divorce;
- termination of domestic partner status; or
- dependent child ceasing to be a dependent as defined by the Medical Plan.

Newborn and Adopted Children

If you give birth or adopt a child while you are on COBRA continuation coverage, you may enroll your new child for COBRA coverage within 31 calendar days following the date of the birth or adoption. Your newborn or adopted child will be a "qualified beneficiary." This means that your child will have independent election rights and multiple qualifying event rights. (Refer to *Multiple Qualifying Events*.)

In Case of Disability

You and your covered dependents may be eligible for up to 29 months of continued coverage if you or your dependents receive a determination from the Social Security Administration stating that you or your dependents were disabled at the time you elected COBRA coverage or at any time during the first 60 days of COBRA coverage, provided the disability lasts at least until the end of the 18-month period of continuation coverage.

You must notify the Duke Energy myHR Service Center of any Social Security Administration disability determination in writing within the initial 18-month coverage period and within 60 days of the determination. Your verbal notice is not binding until confirmed in writing and the Duke Energy myHR Service Center receives a copy of the Social Security disability determination. You also must notify the Duke Energy myHR Service Center within 30 days of the date you are determined by the Social Security Administration to no longer be disabled.

If You Become Covered by Medicare

If you become entitled to Medicare while you are an active employee and you later experience a qualifying event (e.g., a termination of employment), you and your dependents may be eligible for continued coverage when the qualifying event occurs. If COBRA is elected, coverage for your covered dependents will extend 36 months from the date you first became covered by Medicare or the maximum coverage period for the qualifying event (18 months in the case of termination of employment or reduction in hours) whichever is later.

For example, suppose you are actively employed on January 1, 2018, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2019, your eligible dependents would be eligible for continued coverage until the later of:

- 36 months following the date you become covered for Medicare – January 1, 2021; or

- 18 months following your termination of employment – July 1, 2020

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2021 if COBRA continuation coverage is elected.

Multiple Qualifying Events

If your dependents experience more than one qualifying event while COBRA coverage is active, they may be eligible for an additional period of continued coverage not to exceed 36 months from the date of the first qualifying event.

For example, if you terminate employment, you and your dependents may be eligible for 18 months of continued coverage. During this 18-month period, if your dependent child ceases to be a dependent under the Medical Plan (a second qualifying event), your child may be eligible for an additional period of continued coverage. This period would not exceed a total of 36 months from the date of the loss of your coverage due to your termination (the first qualifying event).

Procedures to Obtain Continued Coverage

Both you and the Company have responsibilities if qualifying events occur that make you or your covered dependents eligible for continued coverage.

You or your covered dependents must notify the Duke Energy myHR Service Center within 60 days when one of these qualifying events occurs:

- you become divorced;
- your domestic partner relationship ends;
- your dependent child is no longer considered an eligible dependent as defined by the Medical Plan; or
- you or an eligible dependent is determined to be disabled by the Social Security Administration.

If these procedures are not followed, or if notice is not provided to the Duke Energy myHR Service Center during the 60-day notice period, then your covered dependents will lose their rights to elect COBRA coverage.

For other qualifying events, such as your death, termination of employment or reduction in work hours, it is the Company's responsibility to notify the COBRA administrator.

Election Period

The Company's COBRA administrator will notify you or your covered dependents of your right to elect continued coverage. Each qualified beneficiary has independent election rights and has 60 days to elect coverage, beginning on the later of:

- the date coverage terminates by reason of the qualifying event, or
- the date notification of the right to elect continued coverage is mailed to you and your covered dependents.

Type of Coverage

If you choose continued coverage, you will initially have the same medical coverage you had on the day before your qualifying event. During your COBRA continuation period, any changes to the medical coverage of similarly situated active employees also will apply to your medical coverage as a COBRA qualified beneficiary. In addition, if your COBRA continuation period extends into a future plan year, you will be able to change your Medical Plan COBRA election for the following plan year during annual enrollment to the same extent that similarly situated active employees are able to change their Medical Plan elections for the following plan year during annual enrollment.

Cost

You and your covered dependents will be required to pay 102% of the full group cost for your continued coverage. The 2% is intended to cover administrative fees. The contributions are paid on an after-tax basis.

You will be asked to pay for coverage in monthly installments. Your first payment will be retroactive to the date of your qualifying event and will be due no later than 45 days after the date you elected continued coverage. Coverage will be effective once the initial premium is paid. Once payment is received, notification of coverage will be passed on to the applicable Claims Administrator. You may refile claims that may have been denied between your benefits termination and your election to continue coverage. You will be required to make monthly payments thereafter, with a 30-day grace period. If the cost or benefits change in the future for active employees, the changes also will affect continued coverage under COBRA. You will be notified of any changes in the cost or benefits associated with your coverage.

Termination of Continued Coverage

COBRA coverage automatically ends if any of the following occurs:

- the COBRA participant fails to make the required contribution on time;
- the Company terminates the Medical Plan for all employees; or
- the COBRA participant becomes covered under another group medical plan (as an employee or otherwise) after the election of COBRA coverage.

Conversion Privilege

The Medical Plan has no conversion privilege. This means that you are not able to convert your coverage under the Medical Plan to an individual policy upon your termination from the Company or when coverage ends.

Qualified Medical Child Support Orders (QMCSOs)

If the Company receives notification that, as a result of a QMCSO, you are required to provide Medical Plan coverage for a dependent child, the Company will:

- notify you (and any other person named in the order) of receipt of the order; and

- within a reasonable period of time (up to 30 days), determine if the child is eligible for coverage under the Medical Plan and notify you in writing of the decision.

As appropriate to the court order, the child will be enrolled for medical coverage, unless there are legal proceedings that dispute the determination. If the court order is disputed, claims processing will be delayed until the dispute is resolved.

If the child's covered expenses are paid by a custodial parent or legal guardian who is not a participant in the Medical Plan, reimbursement of these expenses will be made directly to the custodial parent or legal guardian if required by the order. Custodial parents and legal guardians also may sign claim forms and assign benefits to providers. The Claims Administrator will send notification of payment of providers to the custodial parent.

If you do not comply with the procedures required by the order, the Company may change your coverage status to that required by the court order and deduct the appropriate contributions from your pay at the direction of the court.

Your Role

As a participant in the Medical Plan, please follow the guidelines below.

- File accurate claims. If someone else (other than the provider) files a claim on your behalf, you must review the form before you sign it.
- Review the explanation of benefits when it is returned to you. Make sure that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered.
- Never allow another person to seek medical treatment under your identity.
- Provide complete and accurate information on claim forms and any other forms; answer all questions to the best of your knowledge.

You must notify the applicable Claims Administrator if a provider:

- bills you for services or treatment that you have never received;
- asks you to sign a blank claim form; or
- asks you to undergo tests that you feel are not needed.

Any covered person who knowingly intends to defraud the Medical Plan will be considered guilty of fraud. If you are concerned about any of the charges that appear on a bill or explanation of benefits form or if you know of or suspect any illegal activity, call the applicable Claims Administrator at the toll-free number on your I.D. card. All calls are strictly confidential.

Other Important Information

Plan Sponsor

Duke Energy Corporation is the sole sponsor of the Medical Plan. The Company address, telephone number and employer identification number (EIN) are:

Duke Energy Corporation
550 South Tryon Street
Charlotte, NC 28202
980-373-8649
EIN: 20-2777218

Identification Numbers

If you need to correspond with the federal government about the Medical Plan, you should include in the correspondence the Duke Energy Corporation EIN and the plan number assigned to the Medical Plan. The Medical Plan is a component plan under the Duke Energy Active Health & Welfare Benefit (Financed) Plans, plan number 502.

Funding

Benefits under the Medical Plan generally are provided from funds held by trustees. All Medical Plan claims are paid from the Duke Energy Corporation Welfare Benefits Trust VEBA I with Bank of New York Mellon as trustee. The address for Bank of New York Mellon is:

Bank of New York Mellon
BNY Mellon Center
500 Grant Street
Pittsburgh, PA 15258

The Company also may provide benefits under the Medical Plan from its general assets.

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy Benefits Committee (the "Benefits Committee"). The Benefits Committee has responsibility and authority to control and manage the operation and administration of the Medical Plan, except to the extent delegated or assigned to others.

The Benefits Committee may assign or delegate any of its authority or duties to others. The Benefits Committee has appointed Duke Energy Human Resources to serve as the Initial Claim Administrator and the Duke Energy Claims Committee (the "Claims Committee") to serve as Denied Claim Reviewer for claims as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or any coverage option under the Medical Plan. The Benefits Committee, the Claims Committee and Duke Energy Human Resources may be contacted as follows:

Benefits Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

Claims Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

Duke Energy Human Resources
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

The Benefits Committee has appointed the Claims Administrators to serve as Initial Claim Administrators and Denied Claim Reviewers for claims for benefits under the Medical Plan. The Claims Administrators may be contacted at the addresses listed in the Medical Plan booklets. You also can obtain additional information by contacting the Duke Energy myHR Service Center.

The Benefits Committee, the Claims Committee, Duke Energy Human Resources and the Claims Administrators, and/or any delegate thereof, each within its area of authority and responsibility, have power and discretion to construe and interpret the Medical Plan and to make factual determinations.

Investment Committee

The named fiduciary for the maintenance and investment of the plan assets that are held in the Duke Energy Corporation Welfare Benefits Trust VEBA I is the Duke Energy Investment Committee. The Board of Directors of Duke Energy Corporation appointed the Chairman of the Investment Committee, who in turn appoints the other members of the Investment Committee. Any successor Chairman of the Investment Committee is appointed by the Finance and Risk Management Committee of the Board of Directors of Duke Energy Corporation.

The Investment Committee may be contacted through the following address:

Investment Committee
Director, Long Term Investments
Duke Energy Corporation
550 South Tryon Street, DEC40A
Charlotte, NC 28202

Plan Year

The plan year for the Medical Plan is January 1 through December 31.

Service of Legal Process

The person designated for service of legal process upon the Medical Plan is:

Corporate Secretary
Duke Energy Corporation
550 South Tryon Street

Charlotte, North Carolina 28202

Legal process also may be served upon the Medical Plan's trustee, if applicable, or upon the Benefits Committee as Plan Administrator.

Affiliated Employers of Duke Energy That Have Adopted the Medical Plan

Contact the Duke Energy myHR Service Center for information regarding affiliated employers of Duke Energy that have adopted the Medical Plan.

Claim Determination Procedures

There are two different types of claims that may be made under the Medical Plan...Claims for Medical Plan Benefits and Eligibility or Enrollment Claims.

A Claim for Medical Plan Benefits is a claim for Medical Plan benefits made in accordance with the Medical Plan's procedures for filing benefit claims.

An Eligibility or Enrollment Claim is a claim as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or applicable Medical Plan option made in accordance with the Medical Plan's procedures for filing eligibility or enrollment claims. An Eligibility or Enrollment Claim does not include (i) requests to change your Medical Plan coverage level and/or coverage option due to your failure to take action during the applicable enrollment period, (ii) requests to change your Medical Plan coverage level and/or coverage option based solely on a change in your preferred coverage level and/or coverage option, (iii) disputes regarding the cost of your Medical Plan coverage and/or requests to change your Medical Plan coverage level and/or coverage option due to disputes regarding the cost of your Medical Plan coverage, (iv) requests for reinstatement of Medical Plan coverage if your coverage is terminated for non-payment and you have already exhausted your one-time reinstatement opportunity, (v) requests to change your tobacco user status, which includes requests to complete the Alternate Procedure Certification after the communicated deadline or (vi) requests for the Company to record/count wellness activities completed after the communicated deadline.

Claims for Medical Plan Benefits

The Claims Administrators for your Medical Plan options have the authority to decide initial Claims for Medical Plan Benefits, as the Initial Claim Administrators, and denied Claims for Medical Plan Benefits on review, as the Denied Claim Reviewers. The Company has no discretionary authority with respect to Claims for Medical Plan Benefits.

Claims submission procedures for your Medical Plan benefits are described in the Medical Plan booklets for the Medical Plan options in which you participate. You also can obtain additional information by calling the Duke Energy myHR Service Center. To file a valid Claim for Medical Plan Benefits, you (or your authorized representative) must follow the claim submission procedures for the Medical Plan as described in the Medical Plan booklets applicable to the Medical Plan options in which you participate and any updating materials.

Eligibility or Enrollment Claims

The Benefits Committee has appointed Duke Energy Human Resources to decide Eligibility or Enrollment Claims as the Initial Claim Administrator. Duke Energy Human Resources has delegated its authority to decide Eligibility or Enrollment Claims to Alight Solutions Claims and Appeals Management.

The Benefits Committee has appointed the Claims Committee to perform the fair and impartial review of denied Eligibility or Enrollment Claims on appeal as the Denied Claim Reviewer. The Company has no discretionary authority with respect to the Claims Committee's final determinations regarding Eligibility or Enrollment Claims on appeal.

To file a valid Eligibility or Enrollment Claim, you (or your authorized representative) must follow the claim submission procedures for the Medical Plan as described in this General Information booklet and any updating materials.

Initial Claim

If you have an Eligibility or Enrollment Claim, you (or your authorized representative) must submit a claim initiation form. This form can be obtained by calling the Duke Energy myHR Service Center.

The claim form must be submitted in writing to the address on the form and include:

- a statement that the claim is a "Claim for Eligibility/Enrollment" and identification of the Medical Plan;
- your name, Social Security number, mailing address and daytime telephone number;
- a complete description of the claim, including the eligibility/enrollment issue presented;
- dependent information, if applicable; and
- any additional information you want considered.

A "Claim for Eligibility/Enrollment" must be received by Claims and Appeals Management within 12 months after the date on which you are claiming eligibility/enrollment should have occurred. If your claim is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Claims and Appeals Management will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Claims and Appeals Management's control, it will notify you or your representative within 30 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice also will specify what information is needed. The determination period will be suspended on the date Claims and Appeals Management sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice. You will have at least 45 days to respond to the request for information.

Adverse Determination

In the event of an adverse eligibility or enrollment determination, in whole or in part, you (or your authorized representative) will be notified of the adverse determination in writing.

An adverse determination notification for an Eligibility or Enrollment Claim will contain:

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why such information or material is needed;
- an explanation of the claims review process and the time limits applicable to such process, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review and any time limits for filing such a civil action;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request;
- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances; and
- only to the extent required under applicable federal regulations:
    - information sufficient to identify the claim involved;
    - notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
    - a description of the Medical Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and
    - contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

In addition, any such denial notification will be provided in a culturally and linguistically appropriate manner to the extent required by the Patient Protection and Affordable Care Act and any applicable implementing regulations or other federal agency guidance issued thereunder.

Appeal of Adverse Determination

If you disagree with an adverse eligibility or enrollment determination, you (or your authorized representative) can request a review of the initial determination by submitting a written request to the Claims Committee within 180 calendar days after receipt of the adverse determination. If

your appeal is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

A request to the Claims Committee must be submitted in writing to:

Claims Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202

You may request to examine and receive copies of all documents, records and other information relevant to the claim. The Claims Committee will review the appeal without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person that was involved in making the initial decision regarding the claim, or a subordinate to that person. In addition, if the claim was based in whole or in part on a medical judgment, the Claims Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This person will not be a person (or a subordinate of a person) consulted by Claims and Appeals Management in deciding the initial claim. When reviewing an adverse determination that has been appealed, any new information that you provide that was not available or utilized when the initial determination was made will be considered.

You will be allowed to review the claim file and to provide evidence and testimony as part of the internal claims and appeals process. The Claims Committee will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Medical Plan (or at the direction of the Medical Plan) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, if the denial of your appeal is based on a new or additional rationale, the Claims Committee will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. You will be notified regarding the decision on your appeal within 60 days after receipt of the appeal.

The determination of your appeal will be in writing and, if adverse, will contain:

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- a statement about your right to bring a civil action under Section 502(a) of ERISA and any time limits for filing such a civil action;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request;

- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances;
- the following statement: 'You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency'; and
- only to the extent required under applicable federal regulations:
    - information sufficient to identify the claim involved;
    - notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
    - a description of the Medical Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and
    - contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

In addition, any such denial notification will be provided in a culturally and linguistically appropriate manner to the extent required by the Patient Protection and Affordable Care Act and any applicable implementing regulations or other federal agency guidance issued thereunder. Also, upon request, the Claims Committee will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

For additional information on filing an Eligibility or Enrollment Claim or filing an appeal of an adverse determination, you should contact the Claims Committee.

Voluntary External Review Program

Once you have exhausted the internal claims and appeals process, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. External review is available only after internal appeals are exhausted and only for certain types of adverse benefit determinations, as defined by federal regulations.

If your claim is eligible for external review under applicable federal regulations and you wish to file a request for external review, you must submit your request within four months of the date of your receipt of the Claims Committee's final internal adverse determination on your appeal. If your request for external review is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it. Contact the Claims Committee for more information on how to file a request for external review of your appeal.

The Claims Committee will determine if your appeal is eligible for the voluntary external review program and will provide you with a written notice of its determination. If your request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the

request complete, and, in order to pursue an external review, you must provide the required information within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later. If you fail to provide the required information by the applicable deadline, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

If your claim is eligible for external review, the Claims Committee will assign your claim to an IRO. The IRO will notify you of the acceptance of your claim for external review, and this notice will include a statement that you may submit to the IRO in writing within 10 business days following receipt of the notice any additional information the IRO should consider in conducting the external review.

The IRO will review all of the information and documents it receives in a timely manner as outlined in federal regulations and other applicable guidance. You will receive written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to you or the Medical Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

The external review program is completely voluntary, so you only have to exhaust your internal claim and appeal administrative review rights under the Medical Plan in order to bring a civil action against the Medical Plan. Contact the Claims Committee for more information about the Medical Plan's external review procedures.

Legal Action

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the internal claim and appeal procedure. You may not initiate a legal action against the Claims Administrators, the Medical Plan, the Company, or the Plan Administrator until you have completed the internal appeal processes. No legal action may be brought more than one year following a final decision on the claim under the appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority

Authority to decide initial claims (including claims for Medical Plan benefits) under the Medical Plan and denied claims on review (including denied claims for Medical Plan benefits on review) under the Medical Plan includes the full power and discretion to interpret Medical Plan provisions and to make factual determinations, with the Initial Claim Administrators' and the Denied Claim Reviewers' decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to the particular entity identified as having the authority to decide the initial claim, or to decide the denied claim on review, as applicable.

Right to Change or Terminate the Medical Plan

Duke Energy Corporation reserves the right to amend or terminate the Medical Plan in any respect and at any time. For example, the Medical Plan may be discontinued in part or in its entirety, or what the Medical Plan or Medical Plan option covers or what benefits it provides may be changed. Cost sharing between the Company and covered individuals also is subject to change, which may include initiating or increasing contributions required of employees, retirees, other former employees and their dependents.

The amendment or termination of the Medical Plan may affect the benefits or benefit coverage not only of active employees (and their dependents), but also of former active employees who retired (and their dependents), became disabled, died or whose Company employment has otherwise terminated (and their dependents), and also of any covered person who began receiving benefit coverage or payments prior to the amendment or termination. If such a termination or amendment occurs, affected participants will be notified. The right to amend or terminate the Medical Plan may be exercised by Duke Energy Corporation, or its authorized delegates, and any amendment shall be in writing.

In the event of a complete termination of the Medical Plan, eligible claims for Medical Plan benefits will be paid by the Duke Energy Corporation Welfare Benefits Trust VEBA I to the extent that funds are available.

Statement of Rights

As a participant in the Medical Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Medical Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Medical Plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Medical Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Medical Plan, including collective bargaining agreements, and a copy of the latest

annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- receive a summary of the Medical Plan's annual financial report. The Plan Administrator is required by law to furnish each participant in the Medical Plan with a copy of this summary financial report.
- obtain a copy of the Medical Plan's procedures for determining a Qualified Medical Child Support Order (QMCSO).

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse[5] or dependents if there is a loss of coverage under the Medical Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this General Information Booklet and the other documents governing the Medical Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Medical Plan documents or the latest annual report from the Medical Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court once you have exhausted the Medical Plan's internal claims procedures.

In addition, if you disagree with the Medical Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Medical Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If

[5] Additionally, the Company extends continuation of coverage under COBRA to covered domestic partners if they lose eligibility for coverage in certain situations.

you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

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

Keep Us Informed

It is your responsibility to make sure that your benefits records are correct and that the personal information needed to administer your benefits is current. Promptly review any confirmation and other benefit statements carefully, and immediately advise the Duke Energy myHR Service Center if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child is no longer an eligible dependent, contact the Duke Energy myHR Service Center as soon as possible.

A Final Note

Although this General Information Booklet and the other documents that comprise the SPD describe the principal features of the Medical Plan that are generally applicable, the SPD is only a summary. The complete provisions of the Medical Plan are set forth in the plan documents, which are available upon request from Duke Energy Human Resources. An SPD is an overview and is written to be read in its entirety. Descriptions of Medical Plan features should not be taken out of context. Inquiries about specific situations should be directed in writing to Duke Energy Human Resources. Changes to the Medical Plan, pending revision of the SPD, will be communicated in benefit newsletters, letters, Duke Energy Portal announcements and/or enrollment materials. In the event of a conflict between this SPD or any other communication regarding the Medical Plan and the plan documents themselves, the plan documents control. Remember, the Medical Plan may not be amended by oral or written communications.

The Medical Plan, this SPD and your Medical Plan participation are not employment contracts, and do not give any employee the right to continue to be employed by the Company. Employees may resign and are subject to discipline, discharge or layoff as if the SPD had never been published and the Medical Plan had never gone into effect.

The Medical Plan complies with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 888.465.1300. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888.465.1300. 注意：如果您說中文 (Chinese), 我們免費為您提供語言協助服務。請致電：888.465.1300.

Benefit Booklet

Duke Energy Active Medical Plan
PPO Option

Effective: January 1, 2018
Group Number: 729784

UnitedHealthcare®

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorders Administrator: (877) 214-2930.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740809, Atlanta, GA 30374-0800.
- Online assistance: **www.myuhc.com**.

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy Active Medical Plan's PPO Option. It includes summaries of:

- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions and Limitations;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Duke Energy is solely responsible for paying Benefits described in this Benefit Booklet.

IMPORTANT
The healthcare service, supply or pharmaceutical product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 12, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Please read this Benefit Booklet thoroughly to learn how the Duke Energy Active Medical Plan's PPO Option works. If you have questions call the number on the back of your ID card.

How To Use This Benefit Booklet

- Read the entire Benefit Booklet (including the benefit booklet describing the prescription drug benefit), as well as the General Information Booklet and share them with your family. Together, the General Information Booklet and the Benefit Booklets comprise the Summary Plan Description (SPD) for the Plan's PPO Option. Keep these documents in a safe place for future reference.
- Many of the sections of this Benefit Booklet are related to other sections. You may not have all the information you need by reading just one section.
- You can find or request printed copies of your SPD at **http://resources.hewitt.com/duke-energy** or by contacting the Duke Energy myHR™ Service Center at (888) 465-1300.
- Capitalized words in the Benefit Booklet have special meanings and are defined in Section 12, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 12, *Glossary*.
- Duke Energy and its affiliated companies which are participating in the Plan are also referred to as the Company.

SECTION 2 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Designated Network Benefits, Network Benefits or Non-Network Benefits.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 4, *Plan Highlights*. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 12, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of the Company or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The Network of providers is subject to change. Or you might find that a particular

Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Non-Network Benefits Exception

You may be eligible to receive Benefits for certain non-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a 30 mile radius of your home zip code.You can check a provider's Network status by visiting **www.myuhc.com** or by calling UnitedHealthcare at the toll-free number on your ID card. UnitedHealthcare must approve any Benefits payable under this exception before you receive care.

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other provider chosen by UnitedHealthcare.

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, UnitedHealthcare may require you to select a single Network Physician to provide and coordinate all future Covered Health Services. If you don't make a selection within 31 days of the date UnitedHealthcare notifies you, UnitedHealthcare will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

The Plan Administrator has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits. For Designated Network Benefits and Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare determines the Plan will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the Benefit Booklet.

For Designated Network Benefits and Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a master's level counselor.
    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
    - When a rate is not published by *CMS* for the service, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits (other than Benefits for Network preventive care services and Benefits for which you must pay a Copay). The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Eligible Expenses charged by both Network and non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays do not count toward the Annual Deductible but Copays do count toward the Out-of-Pocket-Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate medical and prescription drug Out-of-Pocket Maximums for the Plan's PPO Option. If your eligible out-of-pocket expenses in a calendar year exceed the applicable annual maximum, the Plan pays 100% of additional Eligible Expenses you incur for Covered Health Services through the end of the calendar year.

The medical Copays and Coinsurance amounts are applied toward the Plan's annual ***medical*** Out-of-Pocket Maximums. This means that once you satisfy your applicable annual ***medical*** Out-of-Pocket Maximums, you do not have to pay any further Copays or Coinsurance amounts for Covered Health Services that are medical expenses. However, if you satisfy the Plan's separate annual ***prescription drug*** Out-of-Pocket Maximums, but have not yet satisfied your applicable annual ***medical*** Out-of-Pocket Maximums, you still have to pay any applicable Copay or Coinsurance amount for Covered Health Services which are medical expenses until you satisfy your applicable annual ***medical*** Out-of-Pocket Maximums.

Eligible Expenses charged by both Network and non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the non-Network individual and family Out-of-Pocket Maximums.

The following table identifies what does and does not apply toward your applicable Network and non- Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays	Yes	No
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

Amounts that do not apply toward your Out-of-Pocket Maximum are always your responsibility to pay, even after you reach your Out-of-Pocket Maximum.

SECTION 3 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:
- An overview of the Personal Health Support program.
- Covered Health Services which Require Prior Authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this Benefit Booklet, the Personal Health Support program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share

important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Prior Authorization

The Plan requires prior authorization for certain Covered Health Services. In general, your Network Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. For detailed information on the Covered Health Services that require prior authorization, please refer to Section 5, *Additional Coverage Details.*

It is recommended that you confirm with the Claims Administrator that prior authorization has been obtained for all Covered Health Services listed below as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services for which they fail to obtain prior authorization as required. You can contact the Claims Administrator by calling the number on the back of your ID card.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.
The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization Network providers are generally responsible for obtaining prior authorization from the Claims Administrator or contacting Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from the Claims Administrator prior to receiving a service.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator as shown in Section 5, *Additional Coverage Details* before you receive these Covered Health Services. In many cases, your Non-Network Benefits may be reduced if you do not obtain prior authorization from the Claims Administrator.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

The services that require prior authorization are:

- Ambulance - non-emergent air;
- Clinical Trials;
- Congenital heart disease surgery;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including breast pumps and diabetes equipment for the management and treatment of diabetes;
- Gender Dysphoria treatment as described under *Gender Dysphoria* in Section 5, *Additional Coverage Details*;
- Genetic testing - Breast Cancer Susceptibility Gene (BRCA);
- Home health care for nutritional foods and skilled nursing;
- Hospice care – inpatient;
- Hospital Inpatient Stay - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery;
- Lab, X-Ray and Diagnostics - Outpatient - sleep studies;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); Intensive Outpatient Program treatment; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Neurobiological Disorders - Autism Spectrum Disorder Services-inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment facility); Intensive Outpatient Program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*;
- Private Duty Nursing – outpatient;
- Prosthetic devices;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;

- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance-Related and Addictive Disorders Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication-assisted treatment programs for substance-related and addictive disorders;
- Surgery - sleep apnea surgeries;
- Therapeutic treatments as described in Section 5, *Additional Coverage Details* under *Therapeutic Treatments - Outpatient*;
- Transplants.

For notification timeframes and reductions in Benefits that apply if you do not obtain prior authorization or notify Personal Health Support, see Section 5, *Additional Coverage Details.*

Notification to Personal Health Support is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

(Applicable only to Medicare enrollees who have Plan coverage under COBRA or due to the receipt of long-term disability benefits under a Company-sponsored long-term disability plan).

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to obtain prior authorization before receiving Covered Health Services. Since Medicare pays Benefits first, the Plan will pay Benefits second as described in Section 9, *Coordination of Benefits (COB).*

SECTION 4 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible, Out-of-Pocket Maximum and Lifetime Maximum Benefit.

Plan Features	Network	Non-Network
Copays[1]		
■ Emergency Health Services	$150	$150
■ Physician's Office Services – Primary Physician	$25	60% after you meet the Annual Deductible
■ Physician's Office Services - Specialist	$35	60% after you meet the Annual Deductible
■ Urgent Care Center Services	$50	$50
■ Virtual Visits - Primary Physician	$25	Not Applicable
- Specialist Physician	$35	
Annual Deductible[2]		
■ Individual	$600	$1,200
■ Family (not to exceed the applicable Individual amount per Covered Person)	$1,200	$2,400
Annual Out-of-Pocket Maximum[2]		
■ Individual	$2,500	$5,000
■ Family (not to exceed the applicable Individual amount per Covered Person)	$5,000	$10,000
Lifetime Maximum Benefit[3] There is no dollar limit on the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services and Urgent Care Center Services, a Copay does not apply when you visit a non-Network provider.

[2]Copays do not apply toward the Annual Deductible. Copays do apply toward the medical Out-of-Pocket Maximum. The Annual Deductible does apply toward the Out-of-Pocket Maximum for any Covered Health Services.

[3]Generally the following are considered to be essential Benefits under the Patient Protection and Affordable Care Act:

Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details.*

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Acupuncture Services (Copay is per visit) Acupuncture services will be reviewed after 20 visits for medical necessity	100% after you pay a $35 Copay	60% after you meet the Annual Deductible
Ambulance Services		
■ Emergency Ambulance	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
■ Non-Emergency Ambulance	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Cancer Resource Services (CRS)[2] ■ Hospital Inpatient Stay See *Cancer Resource Services (CRS)* in Section 5, *Additional Coverage Details.*	80% after you meet the Annual Deductible	Not Covered
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a Network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each applicable Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Congenital Heart Disease (CHD) Surgery Services[2]	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only (Copay is per visit)	100% after you pay a $35 Copay	60% after you meet the Annual Deductible
Dental Services -Treatment of a Medical Condition (Copay is per visit)	100% after you pay a $35 Copay	60% after you meet the Annual Deductible
Dental Treatment Covered under Plan (Copay is per visit)	100% after you pay a $35 Copay	60% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each applicable Covered Health Service category in this section.	
Diabetes Self-Management Items ■ Diabetes equipment (insulin pumps and pump supplies only). See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Emergency Health Services – Outpatient (Copay is per visit) If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	100% after you pay a $150 Copay	100% after you pay a $150 Copay
Foot Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in your CVS Caremark Prescription Drug Benefit Booklet	
Home Health Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Kidney Resource Services (KRS)[2] (These Benefits are for Covered Health Services provided through KRS only)	80% after you meet the Annual Deductible	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Lab, X-Ray and Diagnostics - Outpatient	*Physician's office* 100% *All other locations* 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Mental Health Services ■ Inpatient. ■ Outpatient-(Copay is per visit)	80% after you meet the Annual Deductible 100% after you pay a $35 Copay	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient. - (Copay is per visit)	80% after you meet the Annual Deductible 100% after you pay a $35 Copay	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Nutritional Counseling (Copay is per visit) Up to 6 visits per condition per calendar year ■ Primary Physician ■ Specialist Physician	100% after you pay a $25 Copay 100% after you pay a $35 Copay	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Obesity Surgery[2] (The Plan pays Benefits only for Covered Health Services provided through BRS)		
■ Physician's Office Services (Copay is per visit)	100% after you pay a $35 Copay	Not Covered
■ Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	Not Covered
■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	Not Covered
Orthotic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury (Copay is per visit)		
■ Primary Physician	100% after you pay a $25 Copay	60% after you meet the Annual Deductible
■ Specialist Physician	100% after you pay a $35 Copay	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	
Preventive Care Services		
■ Physician Office Services.	100%	60% after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Tests.	100%	60% after you meet the Annual Deductible
■ Breast Pumps.	100%	60% after you meet the Annual Deductible
■ Colonoscopy	1 at 100% every 10 years	60% after you meet the Annual Deductible
Private Duty Nursing - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment ■ Cardiac & Pulmonary Rehabilitation Services	100% for Office Visits	60% after you meet the Annual Deductible
■ All other services (Copay is per visit) - Primary Physician	100% after you pay a $25 Copay	60% after you meet the Annual Deductible
- Specialist Physician	100% after you pay a $35 Copay	60% after you meet the Annual Deductible
See *Rehabilitation Services-Outpatient Therapy* in Section 5, *Additional Coverage Details*, for limits.		
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 150 days per Covered Person per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Spine and Joint Surgeries MANDATORY In order to receive Spine and Joint Surgeries Benefits at a Designated Provider you must contact a Spine and Joint Solution (SJS) Nurse and enroll in the SJS Program prior to surgery. An SJS Nurse may be reached by calling 1-877-214-2930.	80% after you meet the Annual Deductible when you use a Designated Provider	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Substance-Related and Addictive Disorders Services ■ Inpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient (Copay is per visit)	100% after you pay a $35 Copay	60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services (Copay is per visit) Any combination of Network and Non-Network Benefits for oral appliances and associated expenses are limited to a $1,500 maximum per Covered Person per lifetime	100% after you pay a $35 Copay	60% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible Note: Non-Network dialysis is not covered under the Plan.
Transplantation Services Non-Network Benefits include services provided at a Network facility that is not a Designated Provider and services provided at a non-Network facility.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Travel and Lodging (If services rendered by a Designated Provider)	For patient and companion(s) of patient undergoing transplant, obesity surgery, Spine and Joint Surgery services, cancer treatment or Congenital Heart Disease treatment	
Urgent Care Center Services (Copay is per visit)	100% after you pay a $50 Copay	100% after you pay a $50 Copay
Virtual Visits (Copay is per visit) Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	*Primary Physician* 100% after you pay a $25 Copay *Specialist Physician* 100% after you pay a $35 Copay	Not Covered
Vision Examinations (Copay is per visit)	*Routine Vision Examination:* 100% *Non-Routine Vision and refraction eye examination:*	
■ Primary Physician	100% after you pay a $25 Copay	60% after you meet the Annual Deductible
■ Specialist Physician	100% after you pay a $35 Copay	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Wigs Up to a $500 maximum per Covered Person per lifetime	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]You must obtain prior authorization from the Claims Administrator, as described in Section 3, *Personal Health Support and Prior Authorization* to receive full Benefits for certain Covered Health Services. See Section 5, *Additional Coverage Details* for further information. In general, if you visit a Network provider, that provider is responsible for obtaining prior authorization from the Claims Administrator before you receive certain Covered Health Services. See Section 5 *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through BRS, CRS, CHD and KRS at a Designated Provider. For oncology services not provided through CRS or for congenital heart disease surgery services not provided through CHD, or for kidney services not provided through KRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient*, and *Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*. The Plan does not pay any Benefits for obesity surgery not provided through the BRS program.

SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call to obtain prior authorization.

This section supplements the second table in Section 4, *Plan Highlights.*

While the table in Section 4, *Plan Highlights,* provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 7, *Exclusions and Limitations.*

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Acupuncture services will be reviewed after 20 visits for medical necessity.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed services or if goals have previously been met.

Did you know...
You generally pay less out-of-pocket when you use a Network provider?

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 12, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services, please remember that you must obtain prior authorization from the Claims Administrator as soon as possible prior to the transport. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 12, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or a Personal Health Support Nurse.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Provider.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Clinical Trials

The Plan pays for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as determined by UnitedHealthcare, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a

system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:

- Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
- Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises.
If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgery Services

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD surgery services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the number on your ID card for information about these guidelines.

The Plan pays Benefits for Congenital Heart Disease (CHD) surgery services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD surgery services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).

- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by UnitedHealthcare to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you should contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD surgery services received at a Congenital Heart Disease Resource Services program.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises.

If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Dental Services - Accident Only

Accident only dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.

- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within 3 months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for accidental Injury for children. Timing of when the Covered Services will be rendered is determined by the Physician.

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Dental Services – Treatment of a Medical Condition

The Plan covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental treatment required as a result of a medical condition, but which is not an integral component of the treatment of that condition, is not covered (examples include decayed teeth due to dry mouth from medication or disease, or treatment of disease).

Dental Treatment Covered under Plan

The Plan provides Benefits for services provided by a duly licensed doctor, doctor of dental surgery or doctor of dental medicine for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, when the procedure is related to one of the following conditions:

- Congenital deformity, including cleft lip and cleft palate; and
- Removal of:
  - Tumors;
  - cysts which are not related to teeth or associated by dental procedures; and
  - exostoses for reasons other than preparation of dentures.

The Plan provides Benefits for dental implants and related procedures, such as bone grafting associated with the above three conditions.

In addition, Benefits may be provided for dentures and orthodontic braces if used to treat congenital deformity including cleft lip and cleft palate.

When any of the conditions listed above require surgical correction, Benefits for surgery will be subject to a Covered Health Service review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth.

In special cases, Benefits are only provided for anesthesia and facility charges related to dental procedures performed in a hospital or ambulatory surgical center. This Benefit is only available to dependent children below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating provider must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other dental services, including the charge for surgery, are not covered unless specifically covered by the Plan.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	Insulin pumps and pump supplies for the management and treatment of diabetes based upon the medical needs of the Covered Person. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Diabetic supplies such as monitors, syringes, test strips, and lancets are covered under the Plan's prescription drug benefit.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen;
- Equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- Delivery pumps for tube feedings;
- Breast pumps (only as provided under the Health Resources and Services Administration (HRSA) requirement);
- Negative pressure wound therapy pumps (wound vacuums);
- Burn garments;
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital – Inpatient Stay, Rehabilitation Services – Outpatient Therapy* and *Surgery – Outpatient* in this section;
- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part, cranial orthotics (helmets)for correction of positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, shoes/inserts made from a mold of a Covered Person's foot; Charges for custom built orthopedic shoes when medically necessary must be prescribed by a doctor and limited to two (2) pairs per calendar year;
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage;
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every five calendar years.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the five year timeline for replacement.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 2, *How the Plan Works.*

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within 48 hours of the admission or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Foot Care

The Plan covers hygienic and preventive maintenance foot care; cutting or removal of corns and calluses, nail trimming, cutting, or debriding only if the treatment is a Covered Health Service and related to a medical condition.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- **Psychotherapy** for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Services* in this section.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in this section.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided under the Plan's prescription drug benefit.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

  - Clitoroplasty (creation of clitoris).
  - Labiaplasty (creation of labia).
  - Orchiectomy (removal of testicles).
  - Penectomy (removal of penis).
  - Urethroplasty (reconstruction of female urethra).
  - Vaginoplasty (creation of vagina).

  Female to Male:

  - Bilateral mastectomy or breast reduction.
  - Hysterectomy (removal of uterus).
  - Metoidioplasty (creation of penis, using clitoris).
  - Penile prosthesis.
  - Phalloplasty (creation of penis).
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries).

- Scrotoplasty (creation of scrotum).
- Testicular prosthesis.
- Urethroplasty (reconstruction of male urethra).
- Vaginectomy (removal of vagina).
- Vulvectomy (removal of vulva).

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category in this section.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 12, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 12, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization for nutritional foods and skilled nursing, from the Claims Administrator five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) services provided by Designated Providers participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 12, *Glossary.*

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Personal Health Support.
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography, including 3D mammograms (breast tomosynthesis) for screening or diagnosis of breast cancer.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.* Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirement
For Non-Network Benefits for sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement
For Non-Network Benefits for sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.

- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.
- Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management, you must obtain prior authorization for Non-Network Benefits before services are received.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for

which Benefits are available as described under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout (a form of arthritis).
- Renal failure.
- Phenylketonuria (a genetic disorder diagnosed at infancy).
- Hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to six individual sessions per calendar year for each medical condition.

Obesity Surgery

(The Plan pays Benefits only for Covered Health Services provided through BRS)

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician if any of the following are true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea, hypertension, cardiopulmonary condition or diabetes) directly related to, or exacerbated by, obesity.

In addition to meeting the above criteria the following must also be true:

- you have any life threatening or serious medical condition that is weight induced;
- a psychological examination of the Covered Person's readiness and fitness for surgery and the necessary postoperative lifestyle changes has been completed;
- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years;
- you have completed a 6-month Physician supervised weight loss program; and
- you have completed a pre-surgical psychological evaluation.

Coverage of surgical treatment of morbid obesity is limited to adults who are 18 years old or older.

You will have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program, as defined in Section 12, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling the toll-free number on the back of your ID card.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with obesity-related services received at a Designated Provider.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 12, *Glossary* and are not Experimental or Investigational or Unproven Services.

Please remember Non-Network Benefits for obesity surgery are not available.

Orthotic Devices

Refer to the Durable Medical Equipment (DME) section above for details.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-Ray and Diagnostics - Outpatient.*

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA. If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Please Note
Your Physician does not have a copy of your Benefit Booklet, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

If you fail to obtain prior authorization as required, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 6, *Clinical Programs and Services*, for details.

Preventive Care Services

The Plan pays Benefits for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

Examples of preventive care services include routine physical examinations, well-baby and well-child care, immunizations, screening mammograms and prostate screenings. Preventive care Benefits for women defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting or purchasing one breast pump per Pregnancy in conjunction with childbirth.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

Preventive care Benefits for women defined under the Health Resources and Services Administration (HRSA) requirement also include the following:

- Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes;

- Human papillomavirus testing in women with normal cytology results beginning at age 30 and no more frequently than once every three years;
- Annual counseling for sexually transmitted infections;
- Annual counseling and screening for human immune-deficiency virus;
- Comprehensive lactation support and counseling in conjunction with each birth, by a trained provider during pregnancy and/or in the postpartum period;
- All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, as prescribed by a doctor; and
- Annual screening and counseling for interpersonal and domestic violence.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining a breast pump that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), as defined in Section 12, *Glossary*.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator for Private Duty Nursing – Outpatient visits. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every five calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are more than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Prior Authorization Requirement
For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry without regard to the lapse of time between the mastectomy and the reconstructive surgery. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can

contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 12, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedure is performed.
- A non-scheduled Reconstructive Procedure, you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy;
- Occupational therapy;
- Manipulative/Chiropractic Treatment;
- Speech therapy;
- Post-cochlear implant aural therapy;
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- Pulmonary rehabilitation; and

- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- The services are ordered by a Physician and provided and administered by a licensed provider.
- The services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- The services require clinical training in order to be delivered safely and effectively.
- The services are not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. Rehabilitation services will be reviewed after 40 visits for medical necessity. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Also, other than as described under Habilitative Services above, Physical therapy, Occupational therapy and Post-cochlear implant aural therapy will be reviewed after 40 visits for medical necessity.

Manipulative/Chiropractic Treatment will be reviewed after 20 visits for medical necessity.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.

- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient.* Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services.*

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.

- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 150 days per Covered Person per calendar year.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:
- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency), you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Spine and Joint Solution Program MANDATORY

The Spine and Joint Solution (SJS) program is for eligible participants age 18 and older. SJS provides support before, during, and after surgery. Nurses help direct participants to high-quality facilities and provide them case management support.

In scope procedures include:

- Spine Fusion Inpatient Surgery.
- Disc Inpatient Surgery.
- Total Hip Replacement Inpatient Surgery.
- Total Knee Replacement Inpatient Surgery.

If care involves a hospital admission, it may also require that surgery is performed at an SJS Center of Excellence (COE) facility (Designated Provider). To enroll in the program and find the closest COE provider, call 1-877-214-2930 and ask to speak with an SJS Nurse.

You must enroll in the SJS Program to access benefit coverage for spine and joint procedures. Failure to enroll in the program may result in no coverage for your spine & joint procedure.

Enhanced travel benefits may be available to participants who enroll in this program and utilize a Center of Excellence (COE) facility (Designated Provider) for their eligible surgery. See *Travel and Lodging* for details.

As part of the SJS program, most facilities will cover costs related to complications that result from the surgery for a period of 90 days after the surgery. Claims incurred during this period of time will be reviewed to determine if they were a complication related to the surgery or a readmission to the COE and, as a result, if this feature applies.

Benefits are available for spine and joint services that meet the definition of a Covered Health Service, as defined in Section 12, *Glossary* and are not Experimental or Investigational or Unproven Services.

Please remember Non-Network Benefits for inpatient spine and joint surgery are not available.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/ Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as soon as is reasonably possible.
- In addition, for Non-Network Benefits, you must obtain prior authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance-related and addictive disorders.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Prior Authorization Requirement
For Non-Network Benefits for sleep apnea surgery you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible.
If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration (FDA)*-approved TMJ implants only when all other treatment has failed.

Any combination of Network Benefits and Non-Network Benefits for oral appliances and associated expenses is limited to a $1,500 maximum per Covered Person per lifetime.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis* (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

*Non-Network dialysis is not covered under the Plan.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement
For Non-Network Benefits for the following outpatient therapeutic services, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MRI guided focused ultrasound.

If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

The Plan pays Benefits for organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Designated Provider, Network facility that is not a Designated Provider or a non-Network facility.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
For Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Provider, Network Benefits will not be paid. Non-Network Benefits will apply.

For Non-Network Benefits, you must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

For Non-Network Benefits, if you don't obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Travel and Lodging Assistance Program

Travel and Lodging assistance is available under the Plan for you or your eligible family member only if you meet the qualifications for the benefit, including receiving care at a Designated Provider that is more than 50 miles from your home address. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all

transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

- The SJS services program provides a maximum of $2,000 per Covered Person per procedure for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 12, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section. Benefits under this section are available for services to treat a condition that does not meet the definition of Urgent Care.

Virtual Visits

The Plan provides Benefits for virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Vision Examinations

The Plan pays Benefits for:

- Vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment).
- One routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every calendar year;
- Non routine vision exam and refraction eye exam – (Vision Exam - medical/surgical eye care is typically problem-oriented, involving the use of medication and/or surgical procedures to diagnose and treat eye problems, such as glaucoma, pink eye and cataracts. Refractive eye exam – external and internal exam, neurological integrity, pupillary reflexes, versions, biomicroscopy, tonometry, visual acuity, subjective, refraction, accomodative function, binocular function).

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from treatment of malignancy or permanent loss of hair from an accidental injury.

Any combination of Network Benefits and Non-Network Benefits is limited to a $500 maximum per Covered Person per lifetime.

SECTION 6 - CLINICAL PROGRAMS AND SERVICES

What this section includes:
Health and well-being resources available to you, including:
- Condition Management Services; and
- Telephonic Wellness Coaching.

The Company believes in giving you the tools you need to be an educated health care consumer. To that end, the Company has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the Company are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that the Company has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drug products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are available when you log onto **www.myuhc.com**;
- search for Network providers available in your Plan through the online provider directory;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information;
- view and print all of your Explanations of Benefits (EOBs) online; and
- order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports Covered Persons who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 5, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS).*

Condition Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a condition management program at no cost to you. The heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition. These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the condition management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate Covered Persons and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 12, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Telephonic Wellness Coaching

The following provides a description of and the eligibility criteria for each Wellness Coaching program:

Tobacco Cessation Program

A tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support throughout the quitting process for up to one year via toll-free phone and live chat.
- Nicotine replacement therapy (patch, lozenge or gum) sent to you in conjunction with your quit date.

- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in the Quit For Life® program, or if you would like additional information regarding the program and also how to access the program online, please call the number on the back of your ID card.

Stress Management Program

UnitedHealthcare's stress management program will provide you with information to help you manage stress through positive behavioral changes.

UnitedHealthcare will identify Covered Persons who are eligible for the stress management program based on the following criteria:

- Covered Persons who feel tense, anxious, or depressed often and stress has had a noticeable impact on health a lot over the past year.

Nutrition Management Program

UnitedHealthcare's nutrition management program will provide you with information designed to increase your awareness of the importance of proper nutrition, and setting dietary goals, and making lifestyle changes. UnitedHealthcare will identify Covered Persons eligible for the nutrition management program based on the following criteria:

- Covered Persons having a BMI of greater than or equal to 25 and less than 30 and 5-6 servings of high cholesterol food per day. BMI greater than or equal to 30 is prioritized to the weight management program.

Exercise Management Program

UnitedHealthcare's exercise management program will provide you with information to assist you in developing an appropriate exercise regime, giving consideration to factors such as age, weight and other health-related conditions. UnitedHealthcare will also provide exercise educational materials. UnitedHealthcare will identify Covered Persons eligible for the exercise management program based on the following criteria:

- Covered Persons with a BMI of greater than or equal to 25 and less than 30 and have physical activity less than one time per week. BMI greater than or equal to 30 is prioritized to the weight management program.

Heart Health Lifestyle Management Program (Blood Pressure/Cholesterol)

The heart health lifestyle management program provides you with an overall understanding of the factors that affect heart health, such as blood pressure and cholesterol. You receive assistance in making lifestyle changes to reduce risks, in addition to guidance on factors that increase risks, such as lack of proper nutrition and exercise. The identification/stratification criteria for the heart health lifestyle management program are as follows:

- self-report excess weight with a BMI > 25; or
- Covered Person has at least one of the following risk criteria:
  - systolic BP = >/=140 or Diastolic BP = ./=90
  - high Blood Pressure and is on medication
  - cholesterol = 240 or HDL < 40
  - indicates has high cholesterol & is on medication
  - high LDL
  - indicates has heart problems, but no heart failure
- BMI greater than or equal to 30 is prioritized to the weight management program.

Diabetes Lifestyle Management Program

The diabetes lifestyle management program is designed to educate you on proper diet, weight loss/management and exercise. You receive educational materials and guidance focused on prevention through diet, weight loss management, exercise and, when applicable, compliance with prescribed medication. The identification/stratification criteria for the diabetes lifestyle management program are as follows:

- Covered Persons who indicate they have diabetes and self-report excess weight with a BMI > 25. BMI greater than or equal to 30 is prioritized to the weight management program.

Wellness Programs

Real Appeal Program

UnitedHealthcare provides the Real Appeal program, which represents a practical solution for weight-related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.

- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325). TTY users can dial 711 or visit **www.realappeal.com**.

Healthy Pregnancy Program

If you are pregnant and enrolled in the Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 7 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:
- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 5, *Additional Coverage Details.*

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 4, *Plan Highlights.* Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 4, *Plan Highlights.* Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the Benefit Booklet says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Benefit Booklet specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing (holistic tissue massage).
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health.*

This exclusion does not apply to Manipulative/Chiropractic Treatment and non-manipulative/chiropractic osteopathic care for which Benefits are provided as described in Section 5, *Additional Coverage Details.*

Dental

1. Dental implants or root canals, orthodontic braces, removal of teeth and intra-bony cysts, procedures performed for the preparation of the mouth for dentures, except as identified under Dental Treatment Covered under Plan in Section 5, *Additional Coverage Details.*

2. Treatment for the following conditions:
   - injury related to chewing or biting;
   - preventive dental care, diagnosis or treatment of or related to the teeth or gums;
   - periodontal disease or cavities and disease due to infection or tumor.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement.

For information on your dental coverage, contact your Dental Plan provider.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

3. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen prosthetic devices.

5. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details.*

6. Oral appliances for snoring.

7. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details.*

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill (See your CVS Caremark Prescription Drug Benefit Booklet for information about the Plan's prescription drug benefit).

2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Clomiphine (e.g., Clomid®), menotropins (e.g., Repronex®), or other drugs associated with conception by artificial means.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

2. Treatment of flat feet.

3. Treatment of subluxation of the foot.

4. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.
   - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
   - Voice modification surgery.
   - Voice lessons and voice therapy.

2. Reversal of tubal ligation or vasectomy.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - Compression stockings, ace bandages, diabetic strips, and syringes.

   This exclusion does not apply to:

   - Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in Section 5, *Additional Coverage Details.*

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details.*
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *Additional Coverage Details.*

2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen Durable Medical Equipment.

5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 5, *Additional Coverage Details.*

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 7, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 5, *Additional Coverage Details.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder.

4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Transitional Living services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Food of any kind. Foods that are not covered include:

   - nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Food is covered only when the sole source of nutrition and administered via enteral feeding (tube feeding). Infant formula available over the counter is always excluded;
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

3. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement;
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.

- Medical alert systems.
- Motorized beds, non-Hospital beds, comfort beds and mattresses.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 12, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 5, *Additional Coverage Details.*

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs regardless of the reason for the hair loss except for treatment of malignancy or permanent loss of hair from an accidental injury, in which case the Plan pays up to a maximum of $500 per Covered Person per lifetime.

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer).

3. Rehabilitation services and Manipulative/Chiropractic Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders.

5. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy* in Section 5, *Additional Coverage Details.*

6. A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy.

7. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

8. Psychosurgery (lobotomy).

9. Treatment of tobacco dependency, excluding screenings and counseling.

10. Chelation therapy, except to treat heavy metal poisoning.

11. Manipulative/chiropractic Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies.

12. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

13. The following treatments for obesity:

    - Non-surgical treatment of obesity, even if for morbid obesity.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 5, *Additional Coverage Details* and the other requirements described under *Obesity Surgery* in Section 5, *Additional Coverage Details,* are satisfied;.

14. Medical and surgical treatment of excessive sweating (hyperhidrosis).

15. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.

16. Breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details.*

17. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

6. Services and supplies provided at Cancer Treatment Centers of America are not covered under the Plan.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.

3. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue).

4. The reversal of voluntary sterilization.

5. The reversal of tubal ligation or vasectomy.

6. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.

7. Health services and associated expenses for elective surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

8. Services provided by a doula (labor aide).

9. Parenting, pre-natal or birthing classes.

10. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 9, *Coordination of Benefits (COB).*

2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you.

3. While on active military duty.

4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for organ and tissue transplants except as identified under *Transplantation Services* in Section 5, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).

3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 5, *Additional Coverage Details.* Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details.*

Types of Care

1. Custodial Care as defined in Section 12, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 12, *Glossary.*

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Provider concierge services.

5. Private Duty Nursing received on an inpatient basis.

4. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details.*

5. Rest cures.

8. Services of personal care attendants.

9. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3 Eye exercise or vision therapy.

4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

5. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan.
   - That exceed Eligible Expenses or any specified limitation in this Benefit Booklet
   - For which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts.

6. Foreign language and sign language services.

7. Long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and

8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

10. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

11. Health services and supplies that do not meet the definition of a Covered Health Service as defined in Section 12, *Glossary.* Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

    - Medically Necessary.
    - Described as a Covered Health Service in this Benefit Booklet under Section 5, *Additional Coverage Details* and in Section 4, *Plan Highlights.*
    - Not otherwise excluded in this Benefit Booklet under this Section 7, *Exclusions and Limitations.*

SECTION 8 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Deductible, Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or by visiting the Duke Energy Portal. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.

- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Duke Energy and the Plan reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes Duke Energy or the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 9. *Coordination of Benefits.*

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where

Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the following:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the denial;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- a description of the Plan's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action;
- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the denial, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request;

- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- in the case of a denial concerning an Urgent Care claim, a description of the expedited review process applicable to such claims; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 12, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 18 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 18 month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

This section describes what happens if a claim for Benefits is denied, how you can appeal a denied claim and the first and second level internal appeals processes. At the end of this section is a table which describes the time frames that you and UnitedHealthcare are required to follow in connection with the internal claims and appeals processes.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a concurrent claim determination, including a rescission of coverage, as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.

- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 740809
Atlanta, Georgia 30374

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal, and will take into account all comments, documents, records and other information you submit relating to your claim for Benefits, without regard to whether such information was submitted or considered in the initial denial. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

To the extent required by applicable law, UnitedHealthcare will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan (or at the direction of the Plan) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, to the extent required by applicable law, if the denial of your appeal is based on a new or additional rationale, UnitedHealthcare will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. The written explanation will include the following:

- information sufficient to identify the claim involved;

- the specific reason or reasons for the adverse determination of your appeal;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the determination of your appeal is based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim;
- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate the external appeal process;
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA following any final internal adverse benefit determination and any time limits for filing such a civil action, and about any available voluntary alternative dispute resolution options;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request;
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination. UnitedHealthcare must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and within 30 days after receiving the completed post-service appeal. Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial which will include the information specified above with respect to your first appeal, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S.*

Department of Labor. UnitedHealthcare's decision will be final, unless overturned through the Federal External Review Program described below.

Once you have exhausted the internal claims and appeals process described above, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. See "Federal External Review Program" below for additional information.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims and appeals, depending on the type of claim or appeal. There are three types of claims and appeals:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service claim- a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**

If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal a denied Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal Decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal
*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.	

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance

with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision. If you do not submit a request for standard external review within four months after the date you received UnitedHealthcare's decision, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was requested or provided.
- Did not have the claim denied due to a failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is complete but is not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Department of Labor's Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials necessary to make the request complete. You must provide the required information to UnitedHealthcare within the original four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If you do not provide the required information by the applicable deadline, the claim will be deemed permanently waived and abandoned and you will be precluded from reasserting it under these procedures.

If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives

the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, the IRO considered in reaching its decision;
- a discussion of the principal reason or reasons for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of

care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you as described above with respect to the Standard External Review Process. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator unless you first complete all the steps in the internal appeal processes described in this section. After completing this process, if you want to bring a legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator, you must do so within one year following a final decision on the claim under the internal appeal processes or you lose any rights to bring such an action against the Company, the Plan, the Plan Administrator or the Claims Administrator.

SECTION 9- COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term "allowable expense" is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.

- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated.
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Only expenses normally paid by the Plan will be paid under COB.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your hirthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid the same amount or less than the primary plan paid, the Plan pays no Benefits.
- If this Plan would have paid more than the primary plan paid, the Plan may pay an additional amount.

You will be responsible for any Deductible, Coinsurance or Copay payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense If This Plan is Secondary

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two plans' reasonable and customary charges. If the Plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare.*

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older;
- Individuals with end-stage renal disease, for a limited period of time; and
- Participants not actively working and receiving long-term disability benefits for up to six months.

After a participant who is not actively working has received long-term disability benefits for six months, the Plan will pay Benefits second to Medicare.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare.

If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carrier have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are

payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries;
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name, or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you or your dependents, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been contributed to or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.

- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 11 - OTHER IMPORTANT INFORMATION

What this section includes:

- Your relationship with UnitedHealthcare and the Company.
- Relationships with providers.
- Incentives to providers and you.

Your Relationship with UnitedHealthcare and the Company

In order to make choices about your health care coverage and treatment, the Company believes that it is important for you to understand how UnitedHealthcare interacts with the Plan and how it may affect you. UnitedHealthcare helps administer the Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The Company and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this Benefit Booklet).
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between the Company, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not the Company's agents or employees, nor are they agents or employees of UnitedHealthcare. The Company and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees, agents or employees of Network providers.

The Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the Company and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Company's employees nor are they employees of UnitedHealthcare. The Company and UnitedHealthcare do not

have any other relationship with Network providers such as principal-agent or joint venture. The Company and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employee of the Company for any purpose with respect to the administration or provision of benefits under this Plan.

The Company and the Plan Administrator are solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination of or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as a participant responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.

Information and Records

UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. UnitedHealthcare may request additional information from you to decide your claim for Benefits. UnitedHealthcare will keep this information confidential.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan Administrator and UnitedHealthcare with all information or copies of records relating to the services provided to you. The Plan Administrator and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents. The Plan Administrator and UnitedHealthcare agree that such information and records will be considered confidential.

The Plan Administrator and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan Administrator is required to do by law or regulation. During and after the term of the Plan, the Plan Administrator and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements you should contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary.

UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but you should discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for

any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

SECTION 12 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this Benefit Booklet.

Many of the terms used throughout this Benefit Booklet may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefit Booklet, but it does not describe the Benefits provided by the Plan.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year (other than Benefits for Network preventive care services which are paid at 100% by the Plan even before you satisfy your Annual Deductible. The Deductible is shown in the first table in Section 4, *Plan Highlights.*

Annual Enrollment - the period of time, determined by Duke Energy, during which eligible Employees may enroll themselves and their Dependents under the Plan. Duke Energy determines the period of time that is the Annual Enrollment period.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The BRS program provides:

- Specialized clinical consulting services to Covered Persons to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The CRS program provides:

- Specialized consulting services, on a limited basis, to Covered Persons with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works.*

Company - Duke Energy Corporation and its affiliated companies that are participating in the Plan.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health coverage to certain employees and their dependents whose group health coverage has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works.*

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this Benefit Booklet under Section 4, *Plan Highlights* and Section 5, *Additional Coverage Details.*
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in the General Information Booklet.
- Not otherwise excluded in this Benefit Booklet under Section 7, *Exclusions and Limitations.*

Covered Person – the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person. For purposes of the wellness programs described in Section 6. *Clinical Programs and Services*, "Covered Person" means all domestic Employees who are eligible for the Plan, their Dependents age 18 and over who are eligible for the Plan and each other person who is eligible for the Plan and elects to participate in the wellness program, regardless of whether such person also elects to participate in the Plan.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the General Information Booklet.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or

- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.

Designated Virtual Network Provider – a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by UnitedHealthcare as stated below and as detailed in Section 2, *How the Plan Works.*

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employee – an individual who meets the eligibility requirements described in the General Information Booklet.

Employer - Duke Energy Corporation.

EOB - see Explanation of Benefits (EOB).

ERISA – the Employee Retirement Income Security Act of 1974 (ERISA), the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)

- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 5, *Additional Coverage Details.*
- If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - A strong desire for the primary and/or secondary sex characteristics of the other gender.

- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
  - The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The KRS program provides:

- Specialized consulting services to Covered Persons with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative/Chiropractic Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Sickness, Injury, Mental Illness, substance related and addictive disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Sickness, Injury, Mental Illness, substance related and addictive disorder, disease or its symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on www.UnitedHealthcareOnline.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Services Administrator - the organization or individual designated by the Plan Administrator who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 7, *Exclusions and Limitations.*

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 4, *Plan Highlights* and Section 2, *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 4, *Plan Highlights* and Section 2, *How the Plan Works*, for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - the maximum amount you pay every calendar year. Refer to Section 4, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 2, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The PPO Option under the Duke Energy Active Medical Plan and/or the Duke Energy Active Medical Plan, as appropriate depending on context, each as amended from time to time.

Plan Administrator – The Duke Energy Benefits Committee or its designee.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/ Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan Coinsurance and Deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID

Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Benefit Booklet includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse – your spouse or domestic partner as defined in the General Information Booklet.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Living - Mental Health Services/ Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program – a program that identifies network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your Claims Administrator.

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန် သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនគស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតគេញថ្លៃ សំរាប់សមាជិក ដែលមានឈ្មោះនៅក្នុងប័ណ្ណ ID តំណាងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꮎ ᏱP ᏗCZᏢᏗ Ꮧ4ᏫᎠᏗ ᏂᎪᏯᏭW ᎥᏐ GᏙP ᎱᏍ ᏱR ᏗJAᎱᏗ ACᏫᎠᎱᏗ ᎢΘᏂᏫᎠᏗT, ᎣᏤ0ᏼᏫᎠᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kama‘ilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwụghị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。
28. Karen	[illegible] 0 တက္ပါ.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی نەوت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەلای نای دی کارتی پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo emōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.

Language	Translated Taglines
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit['iz7 'ats'77s bee baa'ahay1 bee n44hozin7g77 bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ਼ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ।
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711

Language	Translated Taglines
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Dum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo''u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܢܬܘܢ ܐܝܬܠܟܘܢ ܢܨܘܒܬܐ ܕܩܒܠܬܘܢ ܚܝܠܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܓܢܐܢܝܬ ܠܫܘܐܠܐ ܡܢ ܚܕ ܡܬܪܓܡܢܐ ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܬܠܝܦܘܢ ܕܐܝܠܗ ܒܟܪܬܐ ܕܝܠܗ ܦܠܚܬܐ ܕܚܘܠܡܢܐ ܘܕܘܫܘ 0. TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711

Language	Translated Taglines
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איד האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

CVS caremark™

Prescription Drug Program Guide for the Duke Energy Active Medical Plan

2018

TABLE OF CONTENTS

SECTION 1 – WELCOME

The Duke Energy Active Medical Plan ("Medical Plan") options include outpatient prescription drug coverage currently administered by CVS Caremark. CVS Caremark works with Duke Energy Corporation ("Duke Energy") (individually or collectively referred to with its affiliated companies as the "Company," as appropriate) to help you improve your health and make informed health care decisions, as well as save money on your prescription drugs.

Your prescription drug program benefits through CVS Caremark include the following features:

- The CVS Caremark retail network consists of more than 64,000 participating retail pharmacies.
- Your long-term prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy.
- Online resources are available at **www.Caremark.com** to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- You can reach CVS Caremark Customer Service representatives, 24 hours a day, 7 days a week at 888-797-8912. Pharmacists are also available around the clock for medication consultations.

CVS Caremark will help protect your privacy as follows:

- CVS Caremark employees follow detailed ethical standards and a comprehensive Code of Conduct regarding your personal health information.
- CVS Caremark pharmacists follow a professional Code of Ethics.

SECTION 2 – HOW THE PROGRAM WORKS

Filling Your Prescription at a Pharmacy Participating in the CVS Caremark Retail Network

You can fill a prescription for up to a 30-day supply at any of over 64,000 retail pharmacies participating in the CVS Caremark retail network. You will simply show your CVS Caremark prescription ID card at the time of your purchase. You will pay the applicable prescription drug co-pay or coinsurance amount.

- If you don't identify yourself to the pharmacist as a CVS Caremark participant, or if you go to a pharmacy that is not participating in the CVS Caremark retail network, you will have to pay the full price when you pick up the prescription and then submit a paper claim to CVS Caremark for reimbursement. You will be reimbursed based on the CVS Caremark negotiated price for the medication, less any required co-pay or coinsurance amount. Retail pharmacies that participate in the CVS Caremark retail network fill prescriptions at an agreed upon discounted price. When you fill prescriptions at a non-participating retail pharmacy, or do not identify yourself as a CVS Caremark participant, you may be charged a price higher than the negotiated price and the result is a higher cost prescription to you.
- If you make a prescription drug purchase at a pharmacy that is participating in the CVS Caremark retail network, do not identify yourself as a CVS Caremark participant by presenting your CVS Caremark prescription ID card and are required to pay full price for the prescription drug purchase, generally, you have up to 14 days from the time your prescription was purchased to return to the pharmacy, present your CVS Caremark prescription ID card and ask the pharmacist to submit the order using the original dispensing date. Please confirm at the time you make your purchase that you can return to have your purchase re-processed. You may be entitled to a refund for the difference between the full price and your applicable co-pay or coinsurance amount. This process will eliminate your need to submit a paper claim to CVS Caremark for reimbursement.

Using the CVS Caremark Maintenance Choice™ Program

Generally, a long-term (maintenance) medication is one that you take on a long-term basis such as those used for diabetes, asthma, high blood pressure, high cholesterol or birth control. Under CVS Caremark's Maintenance Choice program, if you are taking a long-term medication, you must choose to receive 90-day supplies through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy near you. Whether you choose delivery or pick-up, you will pay the same applicable co-pay or coinsurance amount.

Fill limit for long-term medications

The Medical Plan allows three 30-day fills of long-term medications at any pharmacy that participates in the CVS Caremark retail network. After that, the Medical Plan will cover long-term medications only if you have 90-day supplies filled through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy at the applicable 90-day supply co-pay or coinsurance amount. If you do not use the CVS Caremark Mail Service Pharmacy or a CVS

retail pharmacy after the third fill, you will pay 100% of the retail price of the long-term medication.

If you will be obtaining your own prescription, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum).

The list of long-term medications that are part of the Maintenance Choice program is subject to change at any time. Visit **www.Caremark.com** to find out whether your medication is considered a long-term medication and whether it is affected by any Medical Plan limits, or you may call CVS Caremark directly for more information.

Process for Mail Order Medications
There are several methods you may use to fill your newly prescribed long-term medications through the CVS Caremark Mail Service Pharmacy.

- **Option 1**: Ask your doctor to select the CVS Caremark Mail Service Pharmacy using their provider ePrescribing tools, or your physician may call 800.378.5697.

- **Option 2**: Use the CVS Caremark mobile app for your smart phone to photograph your prescription order and submit the new prescription electronically to the CVS Caremark Mail Service Pharmacy.

- **Option 3**: Get started using the CVS Caremark Mail Service Pharmacy with FastStart®. Log on to www.caremark.com/faststart to provide the requested information, and CVS Caremark will contact your doctor for the 90-day prescription you need. You also can call FastStart® toll-free at 800.875.0867 for assistance.

- **Option 4**: Alternatively, you can complete the mail order form, which is available at www.Caremark.com, and send it with your new prescription order and payment method for any applicable copayment to the address on the form. If you have any questions about completing the form, contact Customer Service at 888-797-8912.

Once you fill a prescription through the CVS Caremark Mail Service for the first time, you then have the option to use the automated refill service for future refills by CVS Caremark. Visit www.Caremark.com for more information on the Auto Refill process.

Please note: When a prescription is ordered using the CVS Caremark Mail Service Pharmacy, CVS Caremark will automatically dispense the generic equivalent if one is available and permissible by law, unless your physician has indicated that substitution is not allowed.

Using Mail Order if you have an Immediate Medication Need
If you will be using the CVS Caremark Mail Service Pharmacy, but need to begin taking a long-term medication immediately, have your doctor write two prescriptions:

- The first for up to a 30-day supply to be filled right away at any pharmacy that is participating in the CVS Caremark retail network – your doctor can call/fax this prescription to the pharmacy or provide it to you so you may take it to the pharmacy.
- The second for up to a 90-day supply to be filled through the CVS Caremark Mail Service Pharmacy using one of the methods described above.

Covered Expenses

The following are covered expenses under the Medical Plan unless listed as excluded below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes (100% covered with no co-pay or coinsurance)
- Glucose Monitors
- Over-the-Counter (OTC) Diabetic Supplies (lancets, lancet devices, alcohol wipes 100% covered with no co-pay or coinsurance)
- Oral, Transdermal, Intravaginal and Injectable Contraceptives
- Contraceptive Emergency kits
- Drugs to Treat Impotency (Limits of 6 units per 30 days at retail, and 18 units per 90 days at mail for all dosage forms except Yohimbine)
- Inhaler Assisting Devices
- Peak flow meters
- Fertility Agents (100% covered after standard co-pay, if applicable, up to $2,500 per person per lifetime, then participant pays 50% of the cost of the drug)
- Influenza treatments at 1 treatment course per 180 days
- Zyban and Chantix (limit of 360 days of therapy per lifetime, 100% covered with no co-pay or coinsurance)
- Anti-obesity Agents
- Products packaged as greater than a 30-day supply are covered through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy only

Excluded Expenses

The following are excluded from coverage under the Medical Plan unless specifically listed as a benefit under "Covered Expenses."

- Non-Federal Legend Drugs
- Non-systemic contraceptives, devices
- Smoking Deterrents (except as listed above)
- Nutritional Supplements
- Ostomy Supplies (covered as a medical expense under the Medical Plan)
- Glucowatch Products
- Mifeprex
- Therapeutic devices or appliances (including Diabetic Pumps and supplies, which are covered as a medical expense under the Medical Plan)

- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums (covered as a medical expense under the Medical Plan)
- Biologicals, immunization agents or vaccines (except as noted below for certain routine vaccines)
- Blood or blood plasma products (covered as a medical expense under the Medical Plan)
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or from any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the participant
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug
- New-to-market unapproved products and certain existing unapproved products that may be marketed contrary to the Federal Food, Drug and Cosmetic Act (FFDCA)
- Arestin (covered as a dental expense under the Duke Energy Active Dental Plan)

Medical Plan and Health Care Spending Account

The prescription drug program co-pays and coinsurance amounts are not subject to or applied toward your Medical Plan annual deductibles or ***medical*** out-of-pocket maximums, if applicable. This means that the prescription drug program under the Medical Plan provides applicable benefits for covered prescription drug expenses even before you satisfy your annual deductible, if applicable.

The prescription drug program co-pays and coinsurance amounts are applied toward your Medical Plan annual ***prescription drug*** out-of-pocket maximums, if applicable. This means that once you satisfy your applicable annual ***prescription drug*** out-of-pocket maximums, you do not have to pay any further co-pays or coinsurance amounts for covered prescription drugs. Please note that the Medical Plan has separate annual ***medical*** out-of-pocket maximums. If you satisfy the Medical Plan's separate annual ***medical*** out-of-pocket maximums, but have not yet satisfied your applicable annual ***prescription drug*** out-of-pocket maximums, you still have to pay any applicable co-pay or coinsurance amount for covered prescription drugs until you satisfy your applicable annual ***prescription drug*** out-of-pocket maximums.

If you have enrolled in a Health Care Spending Account (HCSA) and are eligible to access HCSA funds, you may pay any prescription drug co-pays and coinsurance amounts with before-tax dollars by filing for reimbursement from your HCSA or using your HCSA debit card.

SECTION 3 – COVERAGE DETAILS

CVS Caremark Primary/Preferred Drug List

Your co-pay and/or coinsurance amounts for prescription purchases will vary depending on whether your physician prescribes a generic, preferred brand or non-preferred brand medication. By asking your physician to prescribe generic or preferred brand medications, you can help control rising health care costs.

Your prescription drug program incorporates a Primary/Preferred Drug List which lists the Medical Plan's preferred brand medications. The medications included on the list, which change from time to time, are commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings for the participant and the Medical Plan. For the most recent listing and to find out whether a medication is included in the Primary/Preferred Drug List, visit CVS Caremark online at **www.Caremark.com** or call CVS Caremark Customer Service at 888-797-8912. This listing is also available for viewing by employees on the Duke Energy Portal.

Refer to the prescription drug benefit summary on page 21 for more information about applicable co-pays and/or coinsurance amounts for generic, preferred brand and non-preferred brand medications.

Certain Contraceptive Medications Covered at 100%

The following contraceptive medications are covered at 100% (i.e., you do not pay anything when you purchase these items) when received from a pharmacy that is participating in the CVS Caremark retail network or the CVS Caremark Mail Service Pharmacy:

- Generic contraceptive medications; and
- Brand contraceptive medications where there is no generic available.

Note: If a generic version of a brand contraceptive medication becomes available, then only the generic contraceptive medication will be covered at 100%.

Certain Routine Vaccines Covered at 100%

The Medical Plan provides coverage for certain commonly administered vaccines at 100% when you present your CVS Caremark prescription ID card at a pharmacy that is participating in the CVS Caremark retail network. This is an alternative to getting certain immunizations from your doctor. Commonly administered vaccines available at a participating pharmacy through the Medical Plan include the following, where applicable:

- Hepatitis A (Adult)
- Hepatitis A (Child)
- Hepatitis B (Adult)
- Hepatitis B (Child)
- Human Papillomavirus (Gardasil)

- Influenza (Fluzone)
- Meningitis
- MMR (Measles, Mumps, Rubella)
- Pneumonia (Pneumovax)
- Polio (IPV)
- Shingles vaccine (Zostavax)
- TD (Tetanus, Diphtheria)
- Tdap (Tetanus, Diphtheria, Pertussis)

Please Note: Not all local pharmacies are staffed to provide immunizations and some may require a prescription to administer the vaccine based on requirements of particular states. Check with your local pharmacy for vaccine availability before you go.

CVS Caremark Specialty Medications and Specialty Guideline Management

Duke Energy participates in the CVS Caremark Specialty Guideline Management Program. This program supports safe, clinically appropriate and cost-effective use of specialty medications. Under your prescription drug program, some specialty medications may only be covered when ordered through CVS Caremark's specialty care pharmacy. CVS Caremark is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling.

Certain specialty medications such as treatments for Growth Hormone and related disorders, Hepatitis C, Multiple Sclerosis and Anemia will have additional management that ensures that the specialty medication continues to have appropriate lab testing and data reviewed to help ensure utilization of these specialty medications to be:

- clinically appropriate;
- safe; and
- effective for the patient throughout the duration of therapy.

For continued treatment with one of these specialty drugs, a periodic clinical review is required. CVS Caremark will obtain the necessary clinical information from your doctor's office and conduct the review.

The CVS Caremark Specialty Pharmacy provides not only your specialty medicines, but also personalized pharmacy care management services:

- Access to an on-call pharmacist 24 hours a day, seven days a week
- Coordination of care with you and your doctor
- Convenient delivery directly to you or to your doctor's office
- Medicine- and disease-specific education and counseling
- Online support through **www.Caremark.com/specialty**, including disease-specific information and interactive areas to submit questions to pharmacists and nurses

If a covered participant uses medications that are classified by CVS Caremark as specialty medications and wishes to use the prescription drug benefit, the participant should obtain these

medications from CVS Caremark Specialty Pharmacy Services. Most of these same drugs also require prior authorization from CVS Caremark, as described below. These drugs are typically only available in up to a 30-day supply, even if taken on a long-term basis.

All specialty medications undergo external review of the program guidelines by clinical experts to ensure the program is unbiased and consistent with current standards of care and practice.

To answer any questions you may have about specialty medications or to find out what medications are considered to be specialty medications for purposes of the Medical Plan, you may contact CVS Caremark Specialty Pharmacy Services directly at 800-237-2767.

SECTION 4 – SPECIAL PROGRAMS

Step Therapy Program

In order to have coverage for prescription medications in certain drug classes, you must try a generic medication first to treat your condition. If you try (or have tried) a generic medication and it does not work for you, then you may receive coverage for a preferred brand medication that your doctor prescribes. If you try (or have tried) a preferred brand medication and it does not work for you, then you may receive coverage for a non-preferred brand medication that your doctor prescribes.

The amount you pay for your prescription will be lowest when you choose a generic medication. If no generic is available – or if it is not right for you – your Medical Plan provides coverage for preferred brand medications, which may also save you money.

However, if you choose to use a preferred brand medication without trying a generic first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the preferred brand medication. If you choose to use a non-preferred brand medication without trying a generic and preferred brand first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the non-preferred brand medication.

For information regarding the drug classes subject to the Step Therapy Program, call CVS Caremark at 888-797-8912.

Maximum Drug Limitation Program

The Medical Plan prescription drug benefits include quantity limits on certain medications, which are applied to address the problem of overuse of medications that can be unsafe for the patient. By following these guidelines, participants are assured of receiving the appropriate safe dosage recommended by the FDA. This means that:

- The Medical Plan will pay only for up to a specified quantity per 30 or 90-day periods.
- In addition, some medications have limitations on the day's supply of medication that may be dispensed to a patient at any one time.
- In certain drug classes, if the medical condition warrants a greater quantity than the established quantity limit, CVS Caremark will discuss the patient's needs with the patient's physician to determine if a greater quantity is medically necessary to treat the condition.

For information regarding the medications subject to the Maximum Drug Limitation Program, call CVS Caremark at 888-797-8912.

Prior Authorization

To ensure that drugs covered by the Medical Plan are used safely and appropriately, certain medications require that physicians obtain prior authorization from CVS Caremark *before* they are covered. Other classes may be added based upon safety, efficiency and FDA approved therapies. Call CVS Caremark at 888-797-8912 to determine if a medication requires prior authorization. Prior authorization does not guarantee coverage or payment under the Medical Plan.

Prior authorization also is required for a preferred brand medication to be covered prior to trying a generic medication, and for a non-preferred brand medication to be covered prior to trying a generic and preferred brand medication, as described above.

In order for medications which require prior authorization to be covered under the Medical Plan, your physician must obtain authorization from CVS Caremark at 800-294-5979 in advance of treatment with these medications.

Drug Utilization Reviews

Drug utilization reviews may help you guard against drug interaction problems that can occur, for example, when medications are prescribed by more than one physician. When your prescriptions are filled through the CVS Caremark Mail Service Pharmacy or at a pharmacy that is participating in the CVS Caremark retail network (using your CVS Caremark prescription ID card), they are reviewed for any potential drug interactions. This review is especially important if you or your covered family members take several medications or see more than one physician. If there is a question about your prescription, a registered pharmacist may contact your physician before dispensing the medication to discuss any alternatives and recommendations. You will be notified of any change in your prescribed medication. Your doctor makes the final decision on all of your prescription medications.

SECTION 5 – COORDINATION OF BENEFITS

Under the prescription drug program, CVS Caremark will not coordinate benefits for prescription drug expenses with other coverage you may have, except for Medicare as described below. That is, if you and/or your covered family members have prescription drug coverage under another plan, you may submit your prescription drug claims to whichever plan you choose. For example, if your spouse/domestic partner's medical plan does not cover prescription drugs or requires a deductible and coinsurance, you may want to use your CVS Caremark prescription ID card, instead of your spouse/domestic partner's plan, to obtain your prescriptions. Alternatively, if your spouse/domestic partner's medical plan requires co-pays to purchase prescription medications in lieu of deductibles and coinsurance, you may want to use your spouse/domestic partner's plan, instead of your CVS Caremark prescription ID card, to obtain your prescriptions.

Please Note: CVS Caremark does coordinate benefits for Medicare Part B coverage for certain participants. Please see the section titled "Medicare Part B Medications" below for more details.

Medicare Part B Medications

(Applicable only to Medicare Part B enrollees)

If you have Medicare Part B coverage, you will be able to fill prescriptions as described below:

Take your prescription to a Medicare Part B retail pharmacy. If you choose to use a Medicare Part B retail pharmacy for your Medicare Part B medication or supply needs, you will be asked to present your Medicare ID card.

- The participating Medicare Part B retail pharmacy will work with you to bill Medicare on your behalf.
- Most independent pharmacies and national chains are Medicare Part B providers. If you want to locate a retail pharmacy that is a Medicare Part B provider, visit the Medicare website at **www.medicare.gov**.

Medicare Part B allows only 30 days worth of medication except for Diabetic Supplies. For Diabetic Supplies, you can receive up to a 90-day supply; however, you can only test up to 3 times a day. If you test more than 3 times a day, you will need to provide further documentation as to why it is necessary for you to test so often. Further documentation can include the results of blood tests conducted by your physician's office.

All prescriptions must be in writing; CVS Caremark cannot take a verbal prescription over the phone. However, CVS Caremark can accept a faxed copy.

Call CVS Caremark at 888-797-8912 to find out what types of drugs or supplies are covered by Medicare Part B.

CVS Caremark needs to have an original Assignment of Benefits (AOB) form filled out before your Medicare Part B prescriptions can he filled at mail order. If the AOB form is not filled out,

CVS Caremark will divert those prescriptions and make an outbound call to obtain a copy of the AOB form. An AOB form will also be included in each order; however, you only have to fill out an original once each year. To obtain an AOB form, call CVS Caremark Customer Service at 888-797-8912.

SECTION 6 – CLAIMS PROCEDURES

How to File a Prescription Drug Program Claim

When you fill your prescription at a pharmacy that is participating in the CVS Caremark retail network and identify yourself as a CVS Caremark participant, you will not have to file a claim form. At the time your prescription is filled, you will have to pay the applicable co-pay or coinsurance amount.

If you do not identify yourself to the pharmacist as a CVS Caremark participant, or if you do not use a pharmacy that is participating in the CVS Caremark retail network, you will need to file a claim for reimbursement of your prescription drug expenses through CVS Caremark. When you submit your claim, attach your original receipts and mail your claim to the address shown on the form. An original receipt should show the date of purchase, the name, cost, strength, quantity and days' supply of the medication, the prescription number and the NDC number. When you submit an original receipt, keep a copy for your records. Claim reimbursement is limited to CVS Caremark's discounted price less any required co-pay or coinsurance.

CVS Caremark will consider claims for payment, provided your prescription claim is filed within 15 months from the date of service. Claims filed after 15 months from the date of service will not be considered for payment. For example, if you purchase a covered prescription medication on January 15, 2018, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2019 to receive reimbursement for your expenses.

If you are newly eligible, you have a 45-day grace period for prescription drug claims for purchases at full cost in situations where the prescription ID card was not used. The grace period allows participants to be reimbursed at 100%, less the applicable co-pay or coinsurance amount, for paper claims submitted within 45 days from a participant's initial eligibility effective date with CVS Caremark. For example, a participant who's initial effective date with CVS Caremark is January 1, 2018 would have 45 days (until February 14, 2018) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

To obtain a claim form, call CVS Caremark Customer Service at 1-888-797-8912, or go online to **www.Caremark.com**.

Submit claim forms to:
CVS Caremark
P.O. Box 52196
Phoenix, AZ 85072-2196

Reviews & Appeals

The timing for review of your claim depends on the type of claim you submit, as described below. You may designate an authorized representative to assist you with the claims and appeals process described below.

Review Timing for Post-Service Claims

In the case of a post-service claim, CVS Caremark will notify you of the determination within 15 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CVS Caremark's control, it will notify you within 15 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed. The determination period will be suspended on the date CVS Caremark sends such a notice of missing information, and the determination period will resume on the date you respond to the notice. You will have at least 45 days to respond to the request for information.

For these purposes, a post-service claim is any claim that is not a pre-service claim or an urgent care claim, each as defined below.

Review Timing for Pre-Service Claims (Claims Relating to Prior Authorization)

In the case of a pre-service claim, CVS Caremark will inform you of its decision (whether adverse or not) within a reasonable period of time appropriate to the medical condition, but not later than 15 days after it receives the claim. Under special circumstances, CVS Caremark may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which CVS Caremark expects to render a decision.

If additional information is needed because necessary information is missing from the request, the notice will specify what information is needed. You must provide the specified information to CVS Caremark within 45 days after receiving the notice. The determination period will be suspended on the date CVS Caremark sends a notice of missing information and the determination period will resume on the date you respond to the notice.

If you have not followed the proper procedures for filing your pre-service claim, you will be notified of the failure and the proper procedures to be followed in filing pre-service claims. This notice will be provided to you as soon as possible, but not later than 5 days, following the failure. This notification may be oral, unless you request written notification.

For these purposes, a pre-service claim means any claim for a benefit with respect to which the terms of the prescription drug program condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Review Timing for Urgent Care Claims
If your claim is an urgent care claim, CVS Caremark will notify you of its decision on your claim (whether adverse or not) as soon as possible, but no later than 72 hours after it receives the claim. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable, CVS Caremark will inform you as soon as possible, but no later than 24 hours after it receives the claim, of the specific information necessary to complete the claim. You will have a reasonable amount of time, taking into account the circumstances, but no less than 48 hours, to provide the specified information. CVS Caremark will notify you of its determination on your claim as soon as possible, and no later than 48 hours after the earlier of (1) CVS Caremark's receipt of the specified information and (2) the end of the period provided to you to provide the specified additional information.

If you have not followed the proper procedures for filing your urgent care claim, you will be notified of the failure and the proper procedures to be followed in filing urgent care claims. This notice will be provided to you as soon as possible, but not later than 24 hours, following the failure. This notification may be oral, unless you request written notification.

For these purposes, an urgent care claim is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Notice of Adverse Determination
In the event of an adverse benefit determination, in whole or in part, you will be notified of the adverse determination in writing.

An adverse benefit determination is a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Medical Plan benefit. An adverse benefit determination notification for any prescription drug program claim will contain:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the prescription drug program's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your rights to bring a civil action under section 502(a) of ERISA following any final internal adverse benefit determination on appeal and any time limits for filing such a civil action;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;
- a statement that a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim is available free of charge upon request;
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims;

- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If the adverse benefit determination relates to an urgent care claim, the information described above may be provided to you orally within the required time frame, provided that a written or electronic notification is provided no later than 3 days after the oral notification.

When You Have a Complaint or an Appeal
If your claim is denied, you may request a full review by CVS Caremark within 180 days of the date of the adverse benefit determination. Your written letter of appeal should include the following:

- your name and participant ID number;
- your doctor's name and telephone number;
- the name of the medication; and
- any additional information from your pharmacy or medical provider that will assist CVS Caremark in completing its review of your appeal, such as documents, records, questions or comments.

Documents, records, written comments, and other information in support of your appeal should accompany your request. This information will be considered by CVS Caremark in reviewing your claim. You may request reasonable access to copies of all documents, records, and other information relevant to your claim. CVS Caremark will review your claim without granting any deference to the initial decision regarding your claim. Also, no reviewer may be a person that was involved in making the initial decision regarding your claim, or a subordinate to that person. If the claim was based, in whole or in part, on a medical judgment in reviewing the claim, CVS Caremark will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person (or a subordinate of a person) consulted by CVS Caremark in deciding the initial claim. Your appeal should be mailed to:

Caremark, Inc.
Department of Appeals, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

CVS Caremark can also be reached by fax at 866-689-3092. In the case of an appeal relating to an urgent care claim, you may request an expedited appeal orally by contacting CVS Caremark

at 888-797-8912 or in writing. All necessary information will be transmitted by telephone, fax or other available similarly expeditious manner.

To the extent required by applicable law:

- you will be allowed to review your claim file and to present evidence and testimony as part of the internal claims and appeals process;
- CVS Caremark will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the prescription drug program (or at the direction of the prescription drug program) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date; and
- if the denial of your appeal is based on a new or additional rationale, CVS Caremark will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Timing of Appeal Notification for Post-Service Claims
In the case of a post-service claim, CVS Caremark will notify you of its decision on your appeal within 30 days of its receipt of your request for review.

Timing of Appeal Notification for Pre-Service Claims (Claims Requiring Preauthorization)
In the case of a pre-service claim, CVS Caremark will provide notification of its determination on appeal within a reasonable amount of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

Timing of Appeal Notification for Urgent Care Claims
In the case of an urgent care claim, CVS Caremark will provide notification of its determination on appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request for review.

Notice of Benefit Determination on Appeal
Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate the external appeals process;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and your right to bring an action under ERISA section 502(a) following any final internal adverse benefit determination and any applicable time limits for bringing such an action;

- a statement that copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal are available upon request and free of charge;
- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Second Level Appeal Process for Post-Service Claims
If your post-service claim is denied on appeal, you have a right to bring a second appeal within 30 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in "When You Have a Complaint or Appeal" above. CVS Caremark will notify you of its decision on your appeal within 30 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in "Notice of Benefit Determination on Appeal" above, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Second Level Appeal Process for Pre-Service Claims
If your pre-service claim is denied on appeal, you have a right to bring a second appeal within 15 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in "When You Have a Complaint or Appeal" above. CVS Caremark will notify you of its decision on your appeal within 15 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in "Notice of Benefit Determination on Appeal" above, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Voluntary External Review Program
Once you have exhausted the internal claims and appeals process described above, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. External review is available only after internal appeals are exhausted and is available only for certain types of adverse benefit determinations, as defined by federal regulations.

If you wish to file a request for external review, you must submit your request within 4 months of the date of your receipt of CVS Caremark's final internal adverse determination on your

appeal. Contact CVS Caremark at the telephone number shown on your CVS Caremark prescription ID card for more information on how to file a request for external review of your appeal.

CVS Caremark will determine if your appeal is eligible for the voluntary external review program and will provide you with a written notice of its determination. If your request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the request complete, and, in order to pursue an external review, you must provide the required information within the 4-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If your claim is eligible for external review, CVS Caremark will assign your claim to an IRO. The IRO will notify you of the acceptance of your claim for external review, and this notice will include a statement that you may submit to the IRO in writing within 10 business days following receipt of the notice any additional information the IRO should consider in conducting the external review.

The IRO will review all of the information and documents it receives in a timely manner. You will receive written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the prescription drug program;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

If your request for external review relates to an urgent care claim, CVS Caremark will determine if the appeal is eligible for the voluntary external review program and will provide you with written notice of its determination immediately. If the urgent care claim is eligible for external review, CVS Caremark will assign the urgent care claim to an IRO as described above. The IRO will review all of the information and documents relevant to the appeal, to the extent the information and documents are available and the IRO considers them appropriate. The IRO will provide notice to you and the Medical Plan of the final external review decision as soon as possible, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not provided in writing, the IRO will provide you and the Medical Plan with a written confirmation of its decision within 48 hours after the date of providing the notice.

Legal Action
You have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the internal claims and appeals procedure. You may not initiate a legal action until you have completed the first and second level internal appeal processes. No legal action may be brought more than one year following a final decision on the claim under the internal appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority
The authority to decide initial claims for prescription drug program benefits under the prescription drug program and denied claims for prescription drug benefits on review under the prescription drug program includes the full power and discretion to interpret prescription drug program provisions and to make factual determinations, with CVS Caremark's decisions, interpretations and factual determinations controlling, unless overturned through the voluntary external review program described above. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to CVS Caremark at the address listed above. Call CVS Caremark Customer Service for additional information regarding the appeals process.

This is a guide of covered expenses and expenses not covered under the prescription drug program. This guide contains selected highlights of Duke Energy's employee benefits plans. If any statement herein, or any other communication, conflicts with the applicable plan documents, the plan documents will govern. Duke Energy retains the right to amend, modify or terminate its benefits plans in any respect and at any time, and neither its benefits plans, nor your plan participation, will be considered a contract for future employment. For more information about applicable co-pays, coinsurance and plan limits, please call CVS Caremark Customer Service or visit ***www.Caremark.com****. For more detailed information on the Medical Plan, refer to the Duke Energy Active Medical Plan General Information Booklet and UnitedHealthcare® Benefits Booklet sections of this Summary Plan Description.*

The Duke Energy medical plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 888.465.1300. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888.465.1300. 注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：888.465.1300.

SECTION 7 – PRESCRIPTION DRUG BENEFIT SUMMARY

	CVS Caremark Retail Pharmacy Network For short-term medications (up to a 30-day supply) you pay:	**Maintenance Choice® CVS Caremark Mail Service Pharmacy or CVS Retail Pharmacy** For long-term medications (up to a 90-day supply) you pay:
Certain contraceptive medications and routine vaccines	**$0**	**$0**
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	Lower of **$10** or the cost of the medication*	Lower of **$25** or the cost of the medication*
Preferred Brand Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from the CVS Caremark Primary/Preferred Drug List.	**25%** of the cost of the medication up to a maximum of **$50***	**25%** of the cost of the medication up to a maximum of **$125***
Non-Preferred Brand Medications You will pay the most for medications not on the CVS Caremark Primary/Preferred Drug List.	**50%** of the cost of the medication up to a maximum of **$100***	**50%** of the cost of the medication up to a maximum of **$250***
***Prescription Drug Out-of-Pocket Maximum** These amounts apply to only the prescription drug out-of-pocket maximum	$2,000 per year for individual coverage / $4,000 per year for family coverage	

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DUKE ENERGY®

Retiree Medical Plan

Catastrophic option

January 2018

This document replaces any documents previously issued which described your benefits.

Duke Energy Retiree Medical Plan
General Information

(Pre-65 Retirees)

IMPORTANT NOTICE

This General Information booklet for the Duke Energy Retiree Medical Plan ("Medical Plan") provides information that is applicable to all Medical Plan coverage options available to retirees who are not yet age 65 and their eligible dependents who are not yet age 65. This booklet addresses eligibility for coverage under the Medical Plan, how to enroll, opportunities to make mid-year changes, when coverage ends and how you and your covered dependents may be able to continue coverage if it ends. It also contains information such as who provides coverage, who administers the Medical Plan, who decides claims for benefits, ERISA rights and Duke Energy Corporation's right to amend or terminate the Medical Plan.

The attached Medical Plan booklets and summaries of benefits describe your Medical Plan benefits, applicable deductible, co-pay and co-insurance information, how to submit a claim for Medical Plan benefits and other important information about your Medical Plan.

This General Information booklet, together with the Medical Plan booklets and summaries of benefits, is the Summary Plan Description (SPD) for the Medical Plan as of January 2018 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

TABLE OF CONTENTS

Page

Medical Coverage Availability

Duke Energy Corporation ("Duke Energy") offers you and your eligible dependents a comprehensive Medical Plan with coverage administered by the claims administrators identified in your Medical Plan benefits booklets (the "Claims Administrators"). The Medical Plan includes medical, surgical, hospitalization, prescription drug and disease management benefits.

Based on your location and retiree group, there are various Medical Plan coverage options available, such as high deductible health plan (HDHP), preferred provider organization (PPO) and catastrophic options. If you do not have adequate access to network providers, you may qualify for an out-of-area (OOA) option. All of the Medical Plan options are designed to help you pay for health care expenses.

Duke Energy myHR™ Service Center

If you have any questions about the Medical Plan or the information in this General Information booklet, contact the Duke Energy myHR Service Center at 1-888-465-1300. Information also is available through the *Your Benefits Resources*™ (YBR) website at http://resources.hewitt.com/duke-energy.

Eligibility

Eligible Retirees

If your employment terminates on or after January 1, 2018, to be eligible for retiree coverage under the Medical Plan, at termination of employment you must be:

- employed by Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan (individually or collectively referred to with Duke Energy as the "Company," as applicable) offering access to retiree coverage under the Medical Plan;
- at least age 50 and credited with at least 5 years of retiree eligibility service; and
- under age 65.

Note: You are not eligible for coverage under the Medical Plan if you are a current employee of Duke Energy or its affiliates. If you are a current employee of Duke Energy or its affiliates and eligible for coverage, you must enroll in the Duke Energy Active Medical Plan for medical coverage, even if you are a rehired retiree or an under age 65 eligible dependent of another Company retiree who might otherwise be eligible for coverage under the Medical Plan if you weren't a current employee of Duke Energy or its affiliates.

You also are not eligible for coverage under the Medical Plan, if you are a Legacy Piedmont Employee[1] hired prior to January 1, 2008 (prior to January 1, 2009, if you are a Legacy Piedmont Employee covered under the Nashville bargaining unit contract).

[1] When used in this booklet, the term "Legacy Piedmont Employee" refers to an individual who (1) was employed by Piedmont Natural Gas Company Inc. and its subsidiaries (collectively, "Piedmont") immediately prior to the acquisition of Piedmont by Duke Energy Corporation effective on October 3, 2016 or (2) was hired by Piedmont following such acquisition but prior to 2018.

Other Retiree Eligibility Information

If your employment with Duke Energy and its affiliates terminated before January 1, 2018, your eligibility for retiree coverage is governed by the eligibility rules in effect at that time.

If you enroll for coverage for yourself, you may be able to elect coverage under the Medical Plan for your eligible spouse/domestic partner and/or child(ren) who are under age 65. Please refer to the sections *Enrolling in the Medical Plan* and *Mid-Year Changes* for additional information. Your eligible spouse/domestic partner and/or child(ren) who are age 65 or older may be able to elect individual medical and prescription drug coverage through a Medicare exchange available to eligible retirees who are age 65 or older. Additional information about the individual medical and prescription drug coverage available through the Medicare exchange will be provided to your eligible spouse/domestic partner and/or child(ren) when they reach age 65.

Duke Energy Corporation reserves the right to amend, modify or terminate retiree coverage offered under the Medical Plan at any time, including termination of eligibility.

Eligible Dependents

When you enroll for certain coverage, you may elect to cover your eligible dependents, which may include:

- your eligible spouse
- your eligible domestic partner
- your eligible child(ren)

In order to be eligible for coverage under the Medical Plan, your eligible dependent must be under age 65. Under age 65 eligible dependents of eligible retirees who are age 65 or older are eligible for coverage under the Medical Plan. Your eligible dependents age 65 or older are eligible for individual medical and prescription drug coverage through a Medicare exchange. Additional information about the individual medical and prescription drug coverage available through the Medicare exchange will be provided to your eligible dependent(s) when they reach age 65.

Spouse Eligibility

Your spouse, eligible for coverage as a dependent, is a person to whom you are legally married under applicable law, which may include "common law marriage" and "same-sex marriage."

Generally, for health coverage of a taxpayer's spouse to be tax-free to the taxpayer, the spouse must be recognized as such under applicable state law and any related federal guidance, which may include "common law marriage" and "same-sex marriage."

By enrolling your spouse in the Medical Plan, you are affirmatively representing that your spouse is eligible for coverage under the Medical Plan. Failure to drop your spouse from coverage constitutes a continuous affirmation of your spouse's eligibility.

You must immediately report any spouse who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your spouse's loss of eligibility is not reported

within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible spouse, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your spouse after your spouse ceases to be eligible will be considered a misrepresentation of your spouse's eligibility.

Domestic Partner Eligibility

If you are enrolled in Medical Plan coverage, you can elect coverage for your eligible same- or opposite-sex domestic partner. You and your domestic partner must continuously:

- be each other's sole domestic partner, and intend to remain so indefinitely;
- be at least 18 years of age and mentally competent to enter into a legal contract;
- have lived together in a common household for the immediately preceding 6 consecutive months;
- share financial obligations of, and be jointly responsible for, the common household;
- not be legally married to or legally separated from anyone else, nor in a domestic partnership with anyone else; and
- not be related by blood or marriage to a degree of closeness that would prohibit marriage to one another in your current state of residence.

By enrolling your domestic partner in the Medical Plan, you are affirmatively representing that your domestic partner is eligible for coverage under the Medical Plan. Failure to drop your domestic partner from coverage constitutes a continuous affirmation of your domestic partner's eligibility.

You must immediately report any domestic partner who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your domestic partner's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible domestic partner, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your domestic partner after your domestic partner ceases to be eligible will be considered a misrepresentation of your domestic partner's eligibility.

Child Eligibility

Your child is:

- your biological child, up to age 26; **or**
- your legally adopted child, including a child placed in your home for legal adoption by you as long as the child remains in your home and the adoption procedure has not been terminated, and whether or not the adoption has become final, up to age 26; **or**
- your stepchild, up to age 26; **or**
- your foster child, up to age 26; **or**
- your domestic partner's biological child, legally adopted child (including a child placed in your home for legal adoption by your domestic partner as long as the child remains in your home and the adoption procedure has not been terminated, whether or not the

adoption has become final), stepchild or foster child, who is primarily dependent on you for support, whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26; **or**

- any other child for whom you, your spouse or your domestic partner has legal guardianship, full or joint legal custody or managing conservatorship under a valid court decree, who is primarily dependent on you for support, whom you claim as a dependent for federal income tax purposes and with whom you have a regular parent-child relationship, up to age 26.

In addition, your child may be covered at any age if:

- he or she became physically or mentally incapable of self-support while enrolled in a Company-sponsored medical plan and before reaching the applicable limiting age of 26 and continuously remains incapacitated and enrolled in a Company-sponsored medical plan; **or**
- he or she was physically or mentally incapable of self-support on your date of employment with the Company, was enrolled in a Company-sponsored medical plan as of your employment date and continuously remains incapacitated and enrolled in a Company-sponsored medical plan.

By enrolling a dependent child in the Medical Plan, you are affirmatively representing that the child is eligible for coverage under the Medical Plan. Failure to drop your child from coverage constitutes a continuous affirmation of your child's eligibility. You must immediately report any dependent child who should be dropped from your coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your dependent child's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for an ineligible dependent child, you should contact the Duke Energy myHR Service Center. Any failure to drop coverage for your child after your child ceases to be eligible will be considered a misrepresentation of your child's eligibility.

An eligible child only can be covered by one Company employee or retiree.

Surviving Spouse, Domestic Partner and Child Eligibility

If you die while you and your spouse/domestic partner are covered under the Medical Plan, your surviving spouse/domestic partner may continue Medical Plan coverage by making contribution payment arrangements with the Duke Energy myHR Service Center. This coverage can be continued until the earliest of your spouse's remarriage, your domestic partner's establishment of a new domestic partner relationship, your spouse's/domestic partner's attainment of age 65, the death of your spouse/domestic partner and the date that your spouse/domestic partner becomes eligible for other coverage (e.g., through an employer's plan).

If you are survived by dependent children, their medical coverage may continue for as long as they:

- continue to meet the definition of eligible dependents; and
- make required payments for coverage. Payment arrangements should be coordinated with the Duke Energy myHR Service Center.

This provision applies even if your spouse/domestic partner dies or loses coverage after you.

Your surviving spouse/domestic partner and/or dependent children will be charged for their component of the contribution for coverage. If coverage under the Medical Plan is declined or ends, your covered dependents may be eligible for continued coverage under COBRA for up to 36 months in certain situations.

Your spouse/domestic partner must immediately report any dependents who should be dropped from survivor coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. See *If a Dependent Becomes Ineligible* for a description of what happens if your dependent's loss of eligibility is not reported within 31 calendar days of the loss of eligibility. To drop coverage for ineligible dependents, your spouse/domestic partner should contact the Duke Energy myHR Service Center. Any failure to drop coverage for a dependent after the dependent ceases to be eligible will be considered a misrepresentation of the dependent's eligibility.

See *Termination of Coverage for Non-Payment* for a description of what happens when required payments for coverage are not made.

If you are covered under the Medical Plan and your spouse/domestic partner is an eligible retiree who is covered as your dependent, your spouse/domestic partner may elect retiree coverage under the Medical Plan at the time of your death.

Employee and Retiree Couples

No one may be considered as a dependent of more than one employee or more than one retiree.

Verification of Dependent Status

By enrolling your dependent in the Medical Plan, you are affirmatively representing that your dependent is eligible for coverage under the Medical Plan. You will be required to provide evidence of dependent eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order, adoption papers or proof of joint residency within 30 calendar days following the date of enrollment. If you fail to provide proper evidence of dependent eligibility in a timely manner, coverage for your dependent generally will end 45 calendar days following the date of enrollment. See *Claims Determination Procedures* for a description of how to file an eligibility or enrollment claim if your dependent's Medical Plan coverage ends due to a failure to timely provide evidence of dependent eligibility. If your claim or appeal is granted, coverage for your dependent may be reinstated retroactively to the date coverage for your dependent was dropped.

To continue coverage beyond age 26 for a child who is physically or mentally incapable of self-support, you must provide evidence of your child's incapacity to the Medical Plan Claims Administrator. The application can be obtained by contacting the Duke Energy myHR Service Center. You may be required periodically to provide evidence of the child's continuing incapacity.

If a Dependent Becomes Ineligible

If a covered spouse, domestic partner or dependent child becomes ineligible for coverage during the year (for example, if your child reaches age 26), the individual(s) who become(s) ineligible for coverage will be dropped from your coverage.

You must immediately report any dependents who should be dropped from coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. When you report a dependent's loss of eligibility within 31 calendar days of the loss of eligibility:

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage; and
- changes to your contribution amounts will be made as soon as administratively practicable after the date on which you notify the Duke Energy myHR Service Center that your dependent is no longer eligible.

If you do not inform the Duke Energy myHR Service Center of a covered dependent's ineligibility within 31 calendar days of the loss of eligibility:

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage;
- the coverage provided while your dependent is ineligible will be considered as part of the individual's COBRA coverage period (this period begins on the first day of the month following the month in which eligibility is lost); and
- COBRA contributions (102% of the total cost) will be required to pay for the coverage received since the end of the month in which eligibility was lost if the individual elects continuation of coverage under COBRA.

To drop coverage for ineligible dependents, contact the Duke Energy myHR Service Center.

The Company reserves the right to seek recovery of any benefits paid under the Medical Plan to your ineligible dependents.

Enrolling in the Medical Plan

When You Become Eligible

If you are an eligible retiree as described in the *Eligible Retirees* section above, you may elect retiree coverage under the Medical Plan when you retire. When your employment terminates, if you are an eligible retiree, you can choose to:

- begin Medical Plan coverage immediately or at a later date; or
- decline Medical Plan coverage.

When you enroll in the Medical Plan as an eligible retiree, based on the dependent(s) that you elect to cover, if any, your coverage level will be one of the following:

- Individual Only
- Individual + Spouse/Domestic Partner
- Individual + Child(ren)
- Individual + Family (Spouse/Domestic Partner and Child(ren))

You must make your election within 31 calendar days of becoming eligible for retiree coverage in order for coverage to begin on the date you become an eligible retiree. If you do not make your election within 31 calendar days of becoming eligible, your next opportunity to enroll will be during a subsequent annual enrollment period or within 31 calendar days of a work/life event for which mid-year changes are allowed. Please refer to *At a Later Date* below.

When you are eligible to enroll as a retiree, you can make your Medical Plan election using an online enrollment tool. You will receive additional information about the online enrollment tool when you become eligible. You also can make your Medical Plan election by contacting the Duke Energy myHR Service Center.

By making your coverage election when you are first eligible, you are affirmatively representing that all information provided during enrollment including, but not limited to, the eligibility of any dependents for coverage, is true and correct. If Duke Energy discovers that any information you provide during enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of information, up to and including termination of Medical Plan coverage, and to take other appropriate action.

If you have any questions or need assistance in making your enrollment election, contact the Duke Energy myHR Service Center.

At a Later Date

If you are an eligible retiree and you do not immediately begin retiree coverage under the Medical Plan at your termination of employment, or if you subsequently discontinue your retiree coverage, you can elect to enroll during a subsequent annual enrollment period or within 31 calendar days of a work/life event for which mid-year changes are allowed.

For example, if you are an eligible retiree covered as a dependent of a spouse enrolled as an active employee under the Duke Energy Active Medical Plan, you may elect retiree coverage under the Medical Plan during a future annual enrollment period or within 31 calendar days of a work/life event for which mid-year changes are allowed.

Please refer to *During Annual Enrollment* and *Mid-Year Changes* for additional information.

During Annual Enrollment

Each fall you will have the opportunity to change your Medical Plan election for the following plan year, including changing your coverage option or electing to drop or add eligible dependents. This process is referred to as "annual enrollment." You will receive information and instructions each fall about annual enrollment.

By making (or not changing, as applicable) your coverage election during annual enrollment, you are affirmatively representing that all information provided during annual enrollment, including, but not limited to, the eligibility of any dependents for coverage, is true and correct. If Duke Energy discovers that any information you provide during annual enrollment is incorrect or inaccurate, Duke Energy reserves the right to recover any contribution amounts you should have paid, to recover Medical Plan benefits paid, to take appropriate disciplinary action for falsification of information, up to and including termination of Medical Plan coverage, and to take other appropriate action.

If You Are Rehired

If you retire from the Company as an eligible retiree and are later rehired as an eligible active employee, you will be eligible for coverage as an active employee under the Duke Energy Active Medical Plan. When your employment subsequently terminates, you may be able to reelect retiree coverage under the Medical Plan or individual coverage through an insurance exchange if you are not yet age 65 at that time, or you may be able to elect individual coverage through a Medicare exchange if you are age 65 or older at that time.

Cost of Coverage

The cost of your retiree coverage under the Medical Plan is based on the Medical Plan coverage option you elect and the eligible dependent(s) you choose to cover. The portion of the cost that you must pay depends on multiple factors, including your date of hire, your date of termination and your retiree group. Your eligibility for Company contributions is governed by the eligibility rules in effect at the time of your termination, but remains subject to Duke Energy Corporation's right to amend, modify or terminate the Medical Plan, including termination of eligibility for Company contributions toward the cost of retiree medical coverage.

If you are eligible for a Company contribution toward the cost of retiree medical coverage, the Company contribution may be provided either in the form of subsidized monthly coverage under the Medical Plan or Health Reimbursement Account benefits, depending on your retiree group. If you have questions about your retiree group or the form of any subsidized monthly coverage for which you may be eligible, contact the Duke Energy myHR Service Center.

Information about contribution amounts is available through the YBR website.

Eligibility for Company Contributions toward the Cost of Retiree Medical Coverage

If your employment with Duke Energy and its affiliates ends on or after January 1, 2018 and you satisfy the eligibility criteria specified for your employment classification in the chart below, you may be eligible for a Company contribution toward the cost of retiree medical coverage if you terminate employment after satisfying all applicable requirements.

If your employment with Duke Energy and its affiliates ends on or after January 1, 2018 and you do not satisfy the eligibility criteria specified for your employment classification in the chart below or you do not satisfy all applicable requirements when your employment with Duke Energy and its affiliates ends, you will not be eligible for a Company contribution toward the cost of retiree medical coverage and you will be responsible for paying the full cost of any retiree coverage you elect under the Medical Plan.

If your employment with Duke Energy and its affiliates ended before January 1, 2018, your eligibility for a Company contribution toward the cost of retiree medical coverage is governed by the eligibility rules in effect at that time.

EMPLOYMENT CLASSIFICATION	ELIGIBILITY CRITERIA
All Duke Energy Employees[2] except for Duke Energy Employees represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06, UWUA, IBEW SCU-8, IBEW 1902 and PPF 702	Hired before January 1, 2009*
All Legacy Progress Energy Employees[3], except for Legacy Progress Energy Employees represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06, UWUA, IBEW SCU-8, IBEW 1902 and PPF 702	Hired or rehired before January 1, 2002 and you either were at least age 40 or completed at least 5 years of retiree eligibility service by December 31, 2001
All Legacy Piedmont Employees, except for Legacy Piedmont Employees hired prior to January 1, 2008 (prior to January 1, 2009 for Legacy Piedmont Employees covered under the Nashville bargaining unit contract), except for Legacy Piedmont Employees represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06, UWUA and IBEW SCU-8	Hired before January 1, 2018*

[2]When used in this booklet, the term "Duke Energy Employee" refers to an individual who satisfies either of the following requirements:

- the individual (1) was employed by Duke Energy or its affiliates immediately prior to the merger of Duke Energy Corporation and Progress Energy, Inc. on July 2, 2012, (2) was hired following such merger but prior to January 1, 2014 by Duke Energy or a payroll company that was affiliated with (or has been designated as having been affiliated with) Duke Energy immediately prior to such merger or (3) was hired on or after January 1, 2014 by Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan; or
- the individual (1) was employed by Duke Energy or its affiliates immediately prior to the acquisition of Piedmont Natural Gas Company Inc. and its subsidiaries (collectively, "Piedmont") by Duke Energy effective on October 3, 2016, (2) was hired following such acquisition but prior to 2018 by Duke Energy or a payroll company that was affiliated with (or has been designated as having been affiliated with) Duke Energy immediately prior to such acquisition or (3) was hired on or after January 1, 2018 by Duke Energy or an affiliated Duke Energy company that is participating in the Medical Plan.

[3]When used in this booklet, the term "Legacy Progress Energy Employee" refers to an individual who (1) was employed by Progress Energy, Inc., Duke Energy Progress, Inc. f/k/a Progress Energy Carolinas, Inc., Duke Energy Florida, Inc. f/k/a Progress Energy Florida, Inc. and/or Progress Energy Service Company, LLC (collectively, "Progress Energy") immediately prior to the merger of Duke Energy Corporation and Progress Energy, Inc. on July 2, 2012 or (2) was hired by Progress Energy following such merger but prior to January 1, 2014.

Employees represented by IBEW 1347	Hired before January 1, 2010*
Employees represented by IBEW 1393	Hired before January 1, 2011*
Employees represented by USW 12049 & USW 5541-06	Hired before January 1, 2012*
Employees represented by UWUA	Hired before January 1, 2013*
Employees represented by IBEW SCU-8	Hired or rehired before January 1, 2009

**If you are an eligible retiree and you are rehired on or after the applicable date specified for your employment classification in the chart above you are eligible for access to retiree coverage under the Medical Plan. When you subsequently terminate your employment with Duke Energy and its affiliates, you may be eligible for a Company contribution toward the cost of retiree medical coverage only if, upon your previous termination of employment, you satisfied the eligibility requirements for Company contributions toward the cost of retiree medical coverage in effect at the time of such termination of employment. If you did not satisfy the eligibility requirements in effect at the time of your previous termination, you will be treated as a new hire and will be responsible for paying the full cost of any retiree coverage you elect.*

Paying for Coverage as a Retiree

Initially, you will be billed directly for the monthly contribution for your medical coverage. There are several different options available to you for making payment, which are listed below.

- If you are billed directly each month, you will receive a statement that explains how to make your payments, when they are due and where they need to be sent.
- Rather than receiving a monthly bill, you may set up an automatic withdrawal from your checking or savings account for monthly contribution payments. If you choose this option, a *Direct Debit Authorization* must be completed and returned to the Duke Energy myHR Service Center.
- If you are receiving annuity payments under a Company-sponsored pension plan, you may elect to have your contributions deducted from your monthly pension check by contacting the Duke Energy myHR Service Center. However, if the amount of your contributions is or becomes greater than the amount of your pension annuity payment, you will be switched to a monthly billing arrangement.

If you would like to change your payment method, contact the Duke Energy myHR Service Center.

If you elect coverage for a domestic partner and you are receiving a Company contribution toward the cost of retiree medical coverage in the form of subsidized monthly coverage, the value of the coverage associated with the benefits you elected under the Medical Plan for your domestic partner is considered taxable (or imputed) income to you. This imputed income will be reported as income on a Form W-2 and will be subject to federal and state income tax (if applicable) as well as FICA and FUTA taxes. Please note that the Company does not provide tax advice, and you should consult with your tax advisor for information about the tax consequences of electing coverage for a domestic partner.

The Company is obligated to collect the applicable taxes on the imputed income created by the election of benefits for a domestic partner. Therefore, in addition to reporting the imputed income on your Form W-2, you will be billed for the amount of this tax liability. If you do not pay the bills for the tax liability in a timely manner, you may be subject to termination of any benefit coverage you elected for your domestic partner.

Termination of Coverage for Non-Payment

Your coverage will be terminated for non-payment if:

- you do not make the required payment in full for two months; or
- you call the Duke Energy myHR Service Center to indicate the payment is being sent, but it does not arrive by the due date.

If your coverage is terminated for non-payment, you will receive a Confirmation of Coverage statement indicating that your coverage has been cancelled.

Except in cases of termination of COBRA coverage for non-payment, reinstatement after non-payment is possible if you contact the Duke Energy myHR Service Center no later than three months from the date printed on the Confirmation of Coverage statement. However, past due contributions must be paid in full to reinstate coverage. Reinstatement after non-payment will be allowed only one time. If COBRA coverage is terminated for non-payment, reinstatement is not available.

Any amounts owed in arrears at the time of a death or coverage change will continue to be billed and must be paid.

When Coverage and Contributions Begin

When you make your Medical Plan election as a newly eligible retiree, coverage begins on the date you become eligible (assuming that you make your election within 31 calendar days of becoming eligible). Payments for your coverage begin as soon as administratively practicable following the date that you make your election.

When you make your coverage elections during annual enrollment, coverage begins on January 1 of the following calendar year. Payments for your coverage begin as soon as administratively practicable following January 1 of the following calendar year.

Mid-Year Changes

Enrolling in Coverage Mid-Year

Once you have made your Medical Plan election for the year, you may not change your election during that year to enroll in coverage for yourself and/or your eligible dependents unless you have a work or life event for which a mid-year enrollment change is permitted and the work or life event results in the gain of eligibility for coverage. Specific information about these "work/life" events and allowable mid-year enrollment changes is available by calling the Duke Energy myHR Service Center. A "mid-year enrollment change" refers to any change made to

your coverage during a calendar year due to a work or life event that results in the gain of eligibility for coverage.

If you experience a work/life event for which mid-year enrollment changes are allowed, you have 31 calendar days from the date of the event (for example, your marriage date) to change your election. Otherwise, unless a subsequent work/life event which would allow you to enroll yourself and/or your eligible dependents in coverage occurs, you cannot elect to enroll yourself and/or your eligible dependents in Medical Plan coverage until annual enrollment.

If you are eligible to make enrollment changes, the election you make must be consistent with and on account of the work/life event.

Below is a list of some work/life events for which you may enroll yourself and/or your eligible dependents mid-year:

- You get married
- Your domestic partner becomes eligible for coverage
- The number of your eligible children changes
  - you have, or adopt, a child
  - you become the legal guardian of a child
  - a Qualified Medical Child Support Order (QMCSO) is received[4]
- Your dependent's benefit coverage changes because:
  - he or she loses coverage due to a change in eligibility as a result of a change in employment status or work schedule
  - his or her period of coverage and annual enrollment window is different from yours
- Your or your dependent's COBRA coverage from another employer expires
- You or your dependent loses Medicare or Medicaid
- You or your dependent loses coverage under a group health plan
- There is a significant increase in the cost of coverage under the employer plan in which your dependent participates
- Your period of temporary employment with the Company ends

Dropping Coverage Mid-Year

Once you have made your Medical Plan election for the year, you may elect to drop coverage for yourself and/or one or more covered dependents at any time, even if you do not experience a work/life event. An election to drop coverage for yourself and/or your covered dependents will be effective on a prospective basis only.

[4]If a Qualified Medical Child Support Order is issued requiring medical coverage for your child, you may change your medical coverage election to provide coverage for your child. You also may make an election change to cancel medical coverage for the child if the order requires the child's other parent to provide coverage.

When Your Dependent Is No Longer Eligible

If a covered dependent ceases to be eligible for benefits, your dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage. If you notify the Duke Energy myHR Service Center within 31 calendar days of the loss of eligibility, changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice. See *If a Dependent Becomes Ineligible* for information about the consequences of failing to notify the Duke Energy myHR Service Center within 31 calendar days of a loss of eligibility.

When You Enroll a Dependent Mid-Year

If your change is to add a dependent to your Medical Plan coverage, and your dependent's eligibility for Medical Plan coverage has not previously been verified, you will be required to provide evidence of dependent eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order, adoption papers, or proof of joint residency within 30 calendar days following the date of enrollment. If you fail to provide proper evidence of dependent eligibility in a timely manner, coverage for your dependent generally will end 45 calendar days following the date of enrollment. See *Claims Determination Procedures* for a description of how to file an eligibility or enrollment claim if your dependent's Medical Plan coverage ends due to a failure to timely provide evidence of dependent eligibility. If your claim or appeal is granted, coverage for your dependent may be reinstated retroactively to the date coverage for your dependent was dropped.

When Mid-Year Coverage and Contribution Changes Are Effective

This section outlines the timing of coverage and contribution changes when you (i) elect to start or increase coverage due to a work/life event, (ii) elect to decrease or terminate coverage or (iii) stop or decrease coverage due to a covered individual becoming ineligible for coverage (e.g., divorce or child reaches age 26).

- **Start or Increase Coverage**. If you elect to start or increase your coverage due to a work/life event, your coverage changes on the day the work/life event occurred. In order for the change to take effect on the day the work/life event occurred, you must notify the Duke Energy myHR Service Center within 31 calendar days of the work/life event. Changes to your contribution amounts are effective as soon as administratively practicable after you submit your election changes.
- **Elective Decrease or Termination of Coverage**. If you elect to decrease or terminate coverage, your coverage changes on the first day of the month after you submit your election changes. You may elect to decrease or terminate coverage at any time. Changes to your contribution amounts are effective as soon as administratively practicable after you submit your election changes.
- **Decrease or Termination of Coverage Due to Loss of Eligibility**. Coverage for individuals who are no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage. Changes to your contribution amounts generally are effective as soon as administratively practicable after you submit your election changes provided that you notify the Duke Energy myHR Service Center within 31 days of the loss of eligibility. See *If a Dependent Becomes Ineligible* above for the consequences of failing to notify the Duke Energy myHR Service Center of a covered

individual's ineligibility within 31 calendar days of the loss of eligibility. Note that in the event of your death, coverage for you and your dependents ends on the date of your death. See *Surviving Spouse, Domestic Partner and Child Eligibility* above for information about coverage available to your spouse/domestic partner and/or child if you die while they are covered under the Medical Plan.

Situations Impacting Your Eligibility for Coverage

When You Reach Age 65

When you and your spouse or other dependent reach age 65, you and your spouse or other dependent will be able to purchase individual medical and prescription drug coverage through a Medicare exchange if you choose. The Medical Plan options available to retirees and their spouses and other dependents who have not yet reached age 65 are not available to retirees and their spouses and other dependents who are age 65 or older.

Once you and your spouse or other dependent reach age 65, you will receive additional information that describes your individual health plan choices, coverage costs and how to enroll in individual coverage for yourself and your eligible spouse/dependent.

If You Become Entitled to Medicare Before Age 65

If you become entitled to Medicare before age 65 due to disability or end stage renal disease, you can elect to continue your coverage under the Medical Plan or enroll in individual coverage through a Medicare exchange. If you wish to continue your enrollment in Duke Energy-sponsored coverage, you will be required to enroll in a Medical Plan option that coordinates with Medicare Part B (note that there is no coordination of benefits between the Medical Plan's prescription drug coverage and Medicare Part D). Contact the Duke Energy myHR Service Center for additional information regarding the options available to you when you become entitled to Medicare before age 65.

If you elect to terminate your coverage under the Medical Plan when you become entitled to Medicare before age 65, any of your eligible dependents who are covered under the Medical Plan and are not eligible for Medicare may continue coverage under the Medical Plan until reaching age 65.

If you and/or a covered dependent enroll in a Medicare prescription drug plan for a calendar year, you and/or your covered dependent will not be eligible for coverage under the Medical Plan for that calendar year. Therefore, Medical Plan coverage ends for a calendar year for individuals who enroll in a Medicare prescription drug plan mid-year. Such individuals may be able to enroll for Medical Plan coverage at the next annual enrollment if Medicare prescription drug coverage is dropped for the following calendar year.

Termination of Coverage

When Coverage Ends

Your coverage under the Medical Plan will cease on the earliest of the following dates:

- the last day of the month prior to the month in which you reach age 65;

- the date that you are rehired as an active employee of Duke Energy or its affiliates (e.g., as a regular, fixed-term or temporary employee);
- the last day of the month in which you cease to be an eligible retiree or dependent or otherwise cease to be eligible for coverage under the Medical Plan;
- the end of the period for which your last required contribution was made;
- the date of your death; or
- the date the Medical Plan is discontinued.

Your dependent's coverage will end when your coverage ends, at the end of the period for which your last required contribution was made, on the last day of the month in which you elect not to cover the dependent, on the last day of the month prior to the month in which the dependent reaches age 65 or on the last day of the month in which the dependent otherwise loses eligibility, unless he or she continues his or her coverage under COBRA or through survivor coverage, as applicable. Medical Plan coverage actually will terminate, but it will be reinstated retroactive to the coverage termination date if the COBRA enrollment is properly received and processed. COBRA enrollment forms must be completed and received within 60 days of the event or notification, whichever is later.

If You Become Divorced or Your Domestic Partner Relationship Ends

If you cover a spouse/domestic partner under the Medical Plan and you become divorced or your domestic partner relationship ends, you must drop coverage for your former spouse/domestic partner within 31 calendar days of the divorce or the date on which your domestic partner relationship ends. Your former spouse/domestic partner will then be notified that he or she may continue coverage through COBRA by contacting the COBRA administrator within 60 days of the qualifying event.

See *If a Dependent Becomes Ineligible* for a description of what happens when you either do or do not report your divorce or the end of your domestic partner relationship within 31 calendar days.

To drop coverage for your former spouse/domestic partner, contact the Duke Energy myHR Service Center.

COBRA Continuation Coverage

Under COBRA (Consolidated Omnibus Budget Reconciliation Act), your spouse and eligible dependent children may elect to continue Medical Plan coverage if certain qualifying events occur. Although domestic partners are not entitled to continuation coverage under COBRA, the Company will apply the same rules to a domestic partner as to a spouse.

There also may be other coverage options available to you and your family if you experience a qualifying event. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace.

Continued Coverage for Your Dependents

Your covered dependents may continue their coverage under the Medical Plan for up to 36 months if they lose coverage as a result of your:

- death;
- divorce;
- termination of domestic partner status; or
- dependent child ceasing to be a dependent as defined by the Medical Plan.

Bankruptcy Proceeding

Since you are a retired employee, if you or your eligible dependents lose coverage resulting from a bankruptcy proceeding against the Company, you may qualify for continuation coverage under COBRA.

Procedures to Obtain Continued Coverage

Both your dependent and the Company have responsibilities if qualifying events occur that make your covered dependents eligible for continued coverage.

You or your covered dependents must notify the Duke Energy myHR Service Center within 60 days when one of these qualifying events occurs:

- you become divorced;
- your domestic partner relationship ends; or
- your dependent child is no longer considered an eligible dependent as defined by the Medical Plan.

If these procedures are not followed, or if notice is not provided to the Duke Energy myHR Service Center during the 60-day notice period, then your covered dependents will lose their rights to elect COBRA coverage.

For other qualifying events, such as your death, it is the Company's responsibility to notify the COBRA administrator.

Election Period

The Company's COBRA administrator will notify your covered dependents of the right to elect continued coverage. Each qualified beneficiary has independent election rights and has 60 days to elect coverage, beginning on the later of:

- the date coverage terminates by reason of the qualifying event, or
- the date notification of the right to elect continued coverage is mailed to your covered dependents.

Type of Coverage

If continued coverage is elected, the medical coverage will initially be the same coverage as was in effect on the day before the qualifying event. During the COBRA continuation period, any changes to the medical coverage of similarly situated retirees also will apply to the medical coverage elected as a COBRA qualified beneficiary. In addition, if the COBRA continuation period extends into a future plan year, the Medical Plan COBRA election may be changed for the following plan year during annual enrollment to the same extent that Medical Plan elections can be changed by other similarly situated retirees for the following plan year during annual enrollment.

Cost

Your covered dependents will be required to pay 102% of the full group cost for continued coverage. The 2% is intended to cover administrative fees. The contributions are paid on an after-tax basis.

Your dependent will be asked to pay for coverage in monthly installments. The first payment will be retroactive to the date of the qualifying event and will be due no later than 45 days after the date continued coverage was elected. Coverage will be effective once the initial premium is paid. Once payment is received, notification of coverage will be passed on to the applicable Claims Administrator. Your dependent may refile claims that may have been denied between benefits termination and the election to continue coverage. Your dependent will be required to make monthly payments thereafter, with a 30-day grace period. If the cost or benefits change in the future for retirees, the changes also will affect continued coverage under COBRA. Your dependent will be notified of any changes in the cost or benefits associated with his or her coverage.

Termination of Continued Coverage

COBRA coverage automatically ends if any of the following occurs:

- the COBRA participant fails to make the required contribution on time;
- the Company terminates the Medical Plan for all retirees; or
- the COBRA participant becomes covered under another group medical plan (as an employee or otherwise) after the election of COBRA coverage.

Conversion Privilege

The Medical Plan has no conversion privilege. This means that you are not able to convert your coverage under the Medical Plan to an individual policy when coverage ends.

Qualified Medical Child Support Orders (QMCSOs)

If the Company receives notification that, as a result of a QMCSO, you are required to provide Medical Plan coverage for a dependent child, the Company will:

- notify you (and any other person named in the order) of receipt of the order; and

- within a reasonable period of time (up to 30 days), determine if the child is eligible for coverage under the Medical Plan and notify you in writing of the decision.

As appropriate to the court order, the child will be enrolled for medical coverage, unless there are legal proceedings that dispute the determination. If the court order is disputed, claims processing will be delayed until the dispute is resolved.

If the child's covered expenses are paid by a custodial parent or legal guardian who is not a participant in the Medical Plan, reimbursement of these expenses will be made directly to the custodial parent or legal guardian if required by the order. Custodial parents and legal guardians also may sign claim forms and assign benefits to providers. The Claims Administrator will send notification of payment of providers to the custodial parent.

If you do not comply with the procedures required by the order, the Company may change your coverage status to that required by the court order and require you to pay the appropriate contributions at the direction of the court.

Your Role

As a participant in the Medical Plan, please follow the guidelines below.

- File accurate claims. If someone else (other than the provider) files a claim on your behalf, you must review the form before you sign it.
- Review the explanation of benefits when it is returned to you. Make sure that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered.
- Never allow another person to seek medical treatment under your identity.
- Provide complete and accurate information on claim forms and any other forms; answer all questions to the best of your knowledge.

You must notify the applicable Claims Administrator if a provider:

- bills you for services or treatment that you have never received;
- asks you to sign a blank claim form; or
- asks you to undergo tests that you feel are not needed.

Any covered person who knowingly intends to defraud the Medical Plan will be considered guilty of fraud. If you are concerned about any of the charges that appear on a bill or explanation of benefits form or if you know of or suspect any illegal activity, call the applicable Claims Administrator at the toll-free number on your I.D. card. All calls are strictly confidential.

Other Important Information

Plan Sponsor

Duke Energy Corporation is the sole sponsor of the Medical Plan. The Company address, telephone number and employer identification number (EIN) are:

Duke Energy Corporation
550 South Tryon Street
Charlotte, NC 28202
980-373-8649
EIN: 20-2777218

Identification Numbers

If you need to correspond with the federal government about the Medical Plan, you should include in the correspondence the Duke Energy Corporation EIN and the plan number assigned to the Medical Plan. The Medical Plan is a component plan under the Duke Energy Retiree Health & Welfare Benefit (Financed) Plans, plan number 503.

Funding

The following funding vehicles are, or may be, used to accumulate assets from which Medical Plan claims may be paid: (i) Section 401(h) medical account under the Duke Energy Retirement Cash Balance Plan, (ii) Section 401(h) medical account under the Duke Energy Legacy Pension Plan, (iii) Duke Energy Corporation Welfare Benefits Trust VEBA I, (iv) Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II, (v) Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Non-Bargaining Employees and/or (vi) Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Bargaining Unit Employees. Duke Energy also may provide benefits under the Medical Plan from its general assets.

The trustee for the Section 401(h) medical accounts is:

Duke Energy Corporation Master Retirement Trust
The Northern Trust Company, Trustee
50 South LaSalle Street
Chicago, IL 60675

The trustee for the VEBAs is:

Bank of New York Mellon
BNY Mellon Center
500 Grant Street
Pittsburgh, PA 15258

The trustee for the Piedmont 501(c)(9) Trusts is:

Wells Fargo Institutional Retirement and Trust
1525 West W.T. Harris Blvd., 3C5
Charlotte, NC 28262-8522

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy Benefits Committee (the "Benefits Committee"). The Benefits Committee has responsibility and authority to control and manage the operation and administration of the Medical Plan, except to the extent delegated or assigned to others.

The Benefits Committee may assign or delegate any of its authority or duties to others. The Benefits Committee has appointed Duke Energy Human Resources to serve as the Initial Claim Administrator and the Duke Energy Claims Committee (the "Claims Committee") to serve as Denied Claim Reviewer for claims as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or any coverage option under the Medical Plan. The Benefits Committee, the Claims Committee and Duke Energy Human Resources may be contacted as follows:

Benefits Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

Claims Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

Duke Energy Human Resources
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202
704-382-4703

The Benefits Committee has appointed the Claims Administrators to serve as Initial Claim Administrators and Denied Claim Reviewers for claims for benefits under the Medical Plan. The Claims Administrators may be contacted at the addresses listed in the Medical Plan booklets. You also can obtain additional information by contacting the Duke Energy myHR Service Center.

The Benefits Committee, the Claims Committee, Duke Energy Human Resources and the Claims Administrators, and/or any delegate thereof, each within its area of authority and responsibility, have power and discretion to construe and interpret the Medical Plan and to make factual determinations.

Investment Committee

The named fiduciary for the maintenance and investment of the plan assets that are held in the Duke Energy Corporation Welfare Benefits Trust VEBA I, the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II, the Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Non-Bargaining Employees, the Piedmont Natural Gas Co., Inc. 501(c)(9) Trust for Retired Bargaining Unit Employees and the 401(h) medical accounts under the Duke Energy Corporation Master Retirement Trust is the Duke Energy Investment Committee. The Board of Directors of Duke Energy Corporation appointed the Chairman of the Investment Committee, who in turn appoints the other members of the Investment Committee. Any successor Chairman

of the Investment Committee is appointed by the Finance and Risk Management Committee of the Board of Directors of Duke Energy Corporation.

The Investment Committee may be contacted through the following address:

Investment Committee
Director, Long Term Investments
Duke Energy Corporation
550 South Tryon Street, DEC40A
Charlotte, NC 28202

Plan Year

The plan year for the Medical Plan is January 1 through December 31.

Service of Legal Process

The person designated for service of legal process upon the Medical Plan is:

Corporate Secretary
Duke Energy Corporation
550 South Tryon Street
Charlotte, North Carolina 28202

Legal process also may be served upon the Medical Plan's trustee, if applicable, or upon the Benefits Committee as Plan Administrator.

Affiliated Employers of the Company That Have Adopted the Medical Plan

Contact the Duke Energy myHR Service Center for information regarding affiliated employers of Duke Energy that have adopted the Medical Plan.

Claim Determination Procedures

There are two different types of claims that may be made under the Medical Plan...Claims for Medical Plan Benefits and Eligibility or Enrollment Claims.

A Claim for Medical Plan Benefits is a claim for Medical Plan benefits made in accordance with the Medical Plan's procedures for filing benefit claims.

An Eligibility or Enrollment Claim is a claim as to whether an individual is eligible to participate in or obtain coverage under, or whether an eligible individual is enrolled for participation in or coverage under, the Medical Plan or applicable Medical Plan option made in accordance with the Medical Plan's procedures for filing eligibility or enrollment claims. An Eligibility or Enrollment Claim does not include (i) requests to change your Medical Plan coverage level and/or coverage option due to your failure to take action during the applicable enrollment period, (ii) requests to change your Medical Plan coverage level and/or coverage option based solely on a change in your preferred coverage level and/or coverage option, (iii) disputes regarding the cost of your Medical Plan coverage and/or requests to change your Medical Plan coverage level and/or

coverage option due to disputes regarding the cost of your Medical Plan coverage or (iv) requests for reinstatement of Medical Plan coverage if your coverage is terminated for non-payment and you have already exhausted your one-time reinstatement opportunity.

Claims for Medical Plan Benefits

The Claims Administrators for your Medical Plan options have the authority to decide initial Claims for Medical Plan Benefits, as the Initial Claim Administrators, and denied Claims for Medical Plan Benefits on review, as the Denied Claim Reviewers. The Company has no discretionary authority with respect to Claims for Medical Plan Benefits.

Claims submission procedures for your Medical Plan benefits are described in the Medical Plan booklets for the Medical Plan options in which you participate. You also can obtain additional information by calling the Duke Energy myHR Service Center. To file a valid Claim for Medical Plan Benefits, you (or your authorized representative) must follow the claim submission procedures for the Medical Plan as described in the Medical Plan booklets applicable to the Medical Plan options in which you participate and any updating materials.

Eligibility or Enrollment Claims

The Benefits Committee has appointed Duke Energy Human Resources to decide Eligibility or Enrollment Claims as the Initial Claim Administrator. Duke Energy Human Resources has delegated its authority to decide Eligibility or Enrollment Claims to Alight Solutions Claims and Appeals Management.

The Benefits Committee has appointed the Claims Committee to perform the fair and impartial review of denied Eligibility or Enrollment Claims on appeal as the Denied Claim Reviewer. The Company has no discretionary authority with respect to the Claims Committee's final determinations regarding Eligibility or Enrollment Claims on appeal.

To file a valid Eligibility or Enrollment Claim, you (or your authorized representative) must follow the claim submission procedures for the Medical Plan as described in this General Information booklet and any updating materials.

Initial Claim

If you have an Eligibility or Enrollment Claim, you (or your authorized representative) must submit a claim initiation form. This form can be obtained by calling the Duke Energy myHR Service Center.

The claim form must be submitted in writing to the address on the form and include:

- a statement that the claim is a "Claim for Eligibility/Enrollment" and identification of the Medical Plan;
- your name, Social Security number, mailing address and daytime telephone number;
- a complete description of the claim, including the eligibility/enrollment issue presented;
- dependent information, if applicable; and
- any additional information you want considered.

A "Claim for Eligibility/Enrollment" must be received by Claims and Appeals Management within 12 months after the date on which you are claiming eligibility/enrollment should have occurred. If your claim is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Claims and Appeals Management will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Claims and Appeals Management's control, it will notify you or your representative within 30 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice also will specify what information is needed. The determination period will be suspended on the date Claims and Appeals Management sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice. You will have at least 45 days to respond to the request for information.

Adverse Determination

In the event of an adverse eligibility or enrollment determination, in whole or in part, you (or your authorized representative) will be notified of the adverse determination in writing.

An adverse determination notification for an Eligibility or Enrollment Claim will contain:

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why such information or material is needed;
- an explanation of the claims review process and the time limits applicable to such process, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review and any time limits for filing such a civil action;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request; and
- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances.

Appeal of Adverse Determination

If you disagree with an adverse eligibility or enrollment determination, you (or your authorized representative) can request a review of the initial determination by submitting a written request to

the Claims Committee within 180 calendar days after receipt of the adverse determination. If your appeal is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

A request to the Claims Committee must be submitted in writing to:

Claims Committee
Duke Energy Corporation
550 South Tryon Street, DEC38D
Charlotte, NC 28202

You may request to examine and receive copies of all documents, records and other information relevant to the claim. The Claims Committee will review the appeal without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person that was involved in making the initial decision regarding the claim, or a subordinate to that person. In addition, if the claim was based in whole or in part on a medical judgment, the Claims Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This person will not be a person (or a subordinate of a person) consulted by Claims and Appeals Management in deciding the initial claim. When reviewing an adverse determination that has been appealed, any new information that you provide that was not available or utilized when the initial determination was made will be considered.

You will be notified regarding the decision on your appeal within 60 days after receipt of the appeal. The determination of your appeal will be in writing and, if adverse, will contain:

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- a statement about your right to bring a civil action under Section 502(a) of ERISA and any time limits for filing such a civil action;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request;
- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances; and
- the following statement: 'You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.'

Also, upon request, the Claims Committee will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

For additional information on filing an Eligibility or Enrollment Claim or filing an appeal of an adverse determination, you should contact the Claims Committee.

Legal Action

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the claim and appeal procedure. You may not initiate a legal action against the Claims Administrators, the Medical Plan, the Company, or the Plan Administrator until you have completed the appeal processes. No legal action may be brought more than one year following a final decision on the claim under the appeal processes. If a civil action is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

Discretionary Authority

Authority to decide initial claims (including claims for Medical Plan benefits) under the Medical Plan and denied claims on review (including denied claims for Medical Plan benefits on review) under the Medical Plan includes the full power and discretion to interpret Medical Plan provisions and to make factual determinations, with the Initial Claim Administrators' and the Denied Claim Reviewers' decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to the particular entity identified as having the authority to decide the initial claim, or to decide the denied claim on review, as applicable.

Right to Change or Terminate the Medical Plan

Duke Energy Corporation reserves the right to amend or terminate the Medical Plan in any respect and at any time. For example, the Medical Plan may be discontinued in part or in its entirety, or what the Medical Plan or Medical Plan option covers or what benefits it provides may be changed. Cost sharing between the Company and covered individuals also is subject to change, which may include initiating or increasing contributions required of employees, retirees, other former employees and their dependents.

The amendment or termination of the Medical Plan may affect the benefits or benefit coverage not only of active employees (and their dependents), but also of former active employees who retired (and their dependents), became disabled, died or whose Company employment has otherwise terminated (and their dependents), and also of any covered person who began receiving benefit coverage or payments prior to the amendment or termination. If such a termination or amendment occurs, affected participants will be notified. The right to amend or terminate the Medical Plan may be exercised by Duke Energy Corporation, or its authorized delegates, and any amendment shall be in writing.

In the event of a complete termination of the Medical Plan, eligible claims for Medical Plan benefits will be paid by the Duke Energy Corporation Welfare Benefits Trust VEBA I, the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II and/or the Duke Energy Corporation Master Retirement Trust – 401(h) Account, as applicable, to the extent that funds are available.

Statement of Rights

As a participant in the Medical Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Medical Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Medical Plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Medical Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Medical Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- receive a summary of the Medical Plan's annual financial report. The Plan Administrator is required by law to furnish each participant in the Medical Plan with a copy of this summary financial report.
- obtain a copy of the Medical Plan's procedures for determining a Qualified Medical Child Support Order (QMCSO).

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse[5] or dependents if there is a loss of coverage under the Medical Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this General Information Booklet and the other documents governing the Medical Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, 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.

[5] Additionally, the Company extends continuation of coverage under COBRA to covered domestic partners if they lose eligibility for coverage in certain situations.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Medical Plan documents or the latest annual report from the Medical Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court once you have exhausted the Medical Plan's claims procedures.

In addition, if you disagree with the Medical Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Medical Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

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

Keep Us Informed

It is your responsibility to make sure that your benefits records are correct and that the personal information needed to administer your benefits is current. Promptly review any confirmation and other benefit statements carefully, and immediately advise the Duke Energy myHR Service Center if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child is no longer an eligible dependent, contact the Duke Energy myHR Service Center as soon as possible.

A Final Note

Although this General Information Booklet and the other documents that comprise the SPD describe the principal features of the Medical Plan that are generally applicable, the SPD is only a summary. The complete provisions of the Medical Plan are set forth in the plan documents, which are available upon request from Duke Energy Human Resources. An SPD is an overview and is written to be read in its entirety. Descriptions of Medical Plan features should not be taken out of context. Inquiries about specific situations should be directed in writing to Duke Energy Human Resources. Changes to the Medical Plan, pending revision of the SPD, will be communicated in benefit newsletters, letters and/or enrollment materials. In the event of a conflict between this SPD or any other communication regarding the Medical Plan and the plan

documents themselves, the plan documents control. Remember, the Medical Plan may not be amended by oral or written communications.

Benefit Booklet

Duke Energy Retiree Medical Plan
Catastrophic Option

Effective: January 1, 2018
Group Number: 729784

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorders Administrator: (877) 214-2930.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740809, Atlanta, GA 30374-0800.
- Online assistance: **www.myuhc.com**.

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy Retiree Medical Plan's Catastrophic Option. It includes summaries of:

- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions and Limitations;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Duke Energy is solely responsible for paying Benefits described in this Benefit Booklet.

IMPORTANT
The healthcare service, supply or pharmaceutical product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 12, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Please read this Benefit Booklet thoroughly to learn how the Duke Energy Retiree Medical Plan's Catastrophic Option works. If you have questions call the number on the back of your ID card.

How To Use This Benefit Booklet

- Read the entire Benefit Booklet (including the benefit booklet describing the prescription drug benefit), as well as the General Information Booklet and share them with your family. Together, the General Information Booklet and the Benefit Booklets comprise the Summary Plan Description (SPD) for the Plan's Catastrophic Option. Keep these documents in a safe place for future reference.
- Many of the sections of this Benefit Booklet are related to other sections. You may not have all the information you need by reading just one section.
- You can find or request printed copies of your SPD at **http://resources.hewitt.com/duke-energy** or by contacting the Duke Energy myHR™ Service Center at (888) 465-1300.
- Capitalized words in the Benefit Booklet have special meanings and are defined in Section 12, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 12, *Glossary*.
- Duke Energy and its affiliated companies which are participating in the Plan are also referred to as the Company.

SECTION 2 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Your level of Benefits will be the same if you visit a Network provider or non-Network provider. Because the total amount of Eligible Expenses may be less when you use a Network provider, the portion you pay will be less. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of the Company or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

It is possible that you might not be able to obtain services from a particular Network provider. The Network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Non-Network Benefits Exception

You may be eligible to receive Benefits for certain non-Network Covered Health Services paid at Network provider rates if you do not have access to a Network provider within a 30 mile radius of your home zip code.

You can check a provider's Network status by visiting **www.myuhc.com** or by calling UnitedHealthcare at the toll-free number on your ID card. UnitedHealthcare must approve any Benefits payable under this exception before you receive care.

Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, UnitedHealthcare may require you to select a single Network Physician to provide and coordinate all future Covered Health Services. If you don't make a selection within 31 days of the date UnitedHealthcare notifies you, UnitedHealthcare will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Eligible Expenses

The Plan Administrator has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits. For Designated Network Benefits and Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare determines the Plan will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the Benefit Booklet.

For Designated Network Benefits and Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance or any Deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service

within the geographic market.

- When a rate is not published by *CMS* for the service, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits (other than Benefits for preventive care services and Benefits for which you must pay a Copay). The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to almost all Covered Health Services under the Plan including Covered Health Services provided through the prescription drug program. The only Covered Health Services under the Plan to which the Annual Deductible does not apply are Benefits for which you must pay a Copay and preventive care services and certain preventive medications and vaccines which the Plan covers at 100% even before you satisfy your Annual Deductible. This means that the prescription drug program under the Plan provides applicable benefits for covered prescription drug expenses even before you satisfy your Annual Deductible.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays do not count toward the Annual Deductible but Copays do count toward the Out-of-Pocket-Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay. Copay applies to Emergency Health Services only.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of additional Eligible Expenses you incur for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Applies to the Out-of- Pocket Maximum?
Copays	Yes
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No
Charges that exceed Eligible Expenses	No

Amounts that do not apply toward your Out-of-Pocket Maximum are always your responsibility to pay, even after you reach your Out-of-Pocket Maximum.

SECTION 3 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services which Require Prior Authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this Benefit Booklet, the Personal Health Support program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share

important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Prior Authorization

The Plan requires prior authorization for certain Covered Health Services. In general, your Network Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Benefits, however, for which you are responsible for obtaining prior authorization. For detailed information on the Covered Health Services that require prior authorization, please refer to Section5, *Additional Coverage Details.*

It is recommended that you confirm with the Claims Administrator that prior authorization has been obtained for all Covered Health Services listed below as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services for which they fail to obtain prior authorization as required. You can contact the Claims Administrator by calling the number on the back of your ID card.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

There are some Covered Health Services for which you are responsible for obtaining prior authorization from the Claims Administrator, as shown in Section 5, *Additional Coverage Details,* before you receive these Covered Health Services.

In many cases, your Benefits may be reduced if you do not obtain prior authorization from the Claims Administrator prior to receiving a service, as shown in Section 5, *Additional Coverage Details*. The services that require prior authorization are:

- Ambulance - non-emergent air;
- Clinical Trials;
- Congenital heart disease surgery;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including breast pumps and diabetes equipment for the management and treatment of diabetes;
- Gender Dysphoria treatment as described under *Gender Dysphoria* in Section 5, *Additional Coverage Details*;
- Genetic testing- Breast Cancer Susceptibility Gene (BRCA);
- Home health care for nutritional foods and skilled nursing;
- Hospice care – inpatient;
- Hospital Inpatient Stay - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery;
- Lab, X-Ray and Diagnostics - Outpatient - sleep studies;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); Intensive Outpatient Program treatment; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Neurobiological Disorders - Autism Spectrum Disorder Services-inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment facility); Intensive Outpatient Program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*;
- Private Duty Nursing – outpatient;
- Prosthetic devices;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance-Related and Addictive Disorders Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in

duration, with or without medication management; medication-assisted treatment programs for substance-related and addictive disorders;

- Surgery - sleep apnea surgeries;
- Therapeutic treatments as described in Section 5, Additional Coverage Details under Therapeutic Treatments - Outpatient;
- Transplants.

For notification timeframes and any reductions in Benefits that apply if you do not obtain prior authorization or notify Personal Health Support, see Section 5, *Additional Coverage Details.*

Notification to Personal Health Support is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

(Applicable only to Medicare enrollees who have Plan coverage under COBRA or due to the receipt of long-term disability benefits under a Company-sponsored long-term disability plan).

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to obtain prior authorization before receiving Covered Health Services. Since Medicare pays Benefits first, the Plan will pay Benefits second as described in Section 9, *Coordination of Benefits (COB).*

SECTION 4 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible, Out-of-Pocket Maximum and Lifetime Maximum Benefit.

Plan Features	Network
Copays[1] ■ Emergency Health Services	100% after you pay a $75 Copay
Annual Deductible[1] ■ Individual ■ Family (not to exceed the applicable Individual amount per Covered Person)	$5,900 $17,700
Lifetime Maximum Benefit[2] There is no dollar limit on the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited
Annual Out-of-Pocket Maximum[2] ■ Individual ■ Family (not to exceed the applicable Individual amount per Covered Person)	$5,900 $17,700

[1]Copays do not apply toward the Annual Deductible. Copays do apply toward the Out-of-Pocket Maximum.

[2]Generally the following are considered to be essential Benefits.

Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, *Additional Coverage Details.*

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Acupuncture Services Acupuncture services will be reviewed after 20 visits for medical necessity	100% after you meet the Annual Deductible
Ambulance Services	
■ Emergency Ambulance	100% after you meet the Annual Deductible
■ Non-Emergency Ambulance	100% after you meet the Annual Deductible
Cancer Resource Services (CRS)[2] ■ Hospital Inpatient Stay See *Cancer Resource Services (CRS)* in Section 5, *Additional Coverage Details.*	100% after you meet the Annual Deductible
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each applicable Covered Health Service category in this section.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Congenital Heart Disease (CHD) Surgery Services[2]	100% after you meet the Annual Deductible
Dental Services - Accident Only	100% after you meet the Annual Deductible
Dental Services -Treatment of a Medical Condition	100% after you meet the Annual Deductible
Dental Treatment Covered under Plan	100% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care Diabetes Self-Management Items ■ Diabetes equipment (insulin pumps and pump supplies only). See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each applicable Covered Health Service category in this section. Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 5, *Additional Coverage Details*, for limits	100% after you meet the Annual Deductible
Emergency Health Services – Outpatient (Copay is per visit) If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copay. Benefits for an Inpatient Stay in a Network Hospital will apply instead.	100% after you pay a $75 Copay and after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Foot Care	100% after you meet the Annual Deductible
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section and in your CVS Caremark Prescription Drug Benefit Booklet
Home Health Care	100% after you meet the Annual Deductible
Hospice Care	100% after you meet the Annual Deductible
Hospital - Inpatient Stay	100% after you meet the Annual Deductible
Kidney Resource Services (KRS)[2] (These Benefits are for Covered Health Services provided through KRS only)	100% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient	100% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	100% after you meet the Annual Deductible
Mental Health Services	
■ Inpatient.	100% after you meet the Annual Deductible
■ Outpatient.	100% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient. ■ Outpatient.	 100% after you meet the Annual Deductible 100% after you meet the Annual Deductible
Nutritional Counseling Up to 6 visits per condition per calendar year	100% after you meet the Annual Deductible
Obesity Surgery[2] (The Plan pays Benefits only for Covered Health Services provided through BRS)	100% after you meet the Annual Deductible
Orthotic Devices	100% after you meet the Annual Deductible
Ostomy Supplies	100% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	100% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	100% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	100% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each applicable Covered Health Service category in this section.
Preventive Care Services ■ Physician Office Services. ■ Lab, X-ray or Other Preventive Tests. ■ Breast Pumps. ■ Colonoscopy	 100% 100% 100% 1 at 100% every 10 years

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Private Duty Nursing - Outpatient	100% after you meet the Annual Deductible
Prosthetic Devices	100% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment ■ Cardiac & Pulmonary Rehabilitation Services ■ All other services See *Rehabilitation Services-Outpatient Therapy* in Section 5, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible 100% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 150 days per Covered Person per calendar year	100% after you meet the Annual Deductible
Spine and Joint Surgeries MANDATORY In order to receive Spine and Joint Surgeries Benefits at a Designated Provider you must contact a Spine and Joint Solution (SJS) Nurse and enroll in the SJS Program prior to surgery. An SJS Nurse may be reached by calling 1-877-214-2930.	100% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Substance-Related and Addictive Disorders Services ■ Inpatient. ■ Outpatient.	100% after you meet the Annual Deductible 100% after you meet the Annual Deductible
Surgery - Outpatient	100% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services Benefits for oral appliances and associated expenses are limited to a $1,500 maximum per Covered Person per lifetime	100% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	100% after you meet the Annual Deductible
Transplantation Services (If services rendered by a Designated Provider)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.
Travel and Lodging (If services rendered by a Designated Provider)	For patient and companion(s) of patient undergoing transplant, obesity surgery, Spine and Joint Surgery services, cancer treatment or Congenital Heart Disease treatment
Urgent Care Center Services	100% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% after you meet the Annual Deductible
Vision Examinations	100% after you meet the Annual Deductible
Wigs Up to a $500 maximum per Covered Person per lifetime	100% after you meet the Annual Deductible

[1]You must obtain prior authorization from the Claims Administrator, as described in Section 3, *Personal Health Support and Prior Authorization* to receive full Benefits for certain Covered Health Services. See Section 5, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through BRS, CRS, CHD and KRS at a Designated Provider. For oncology services not provided through CRS or for congenital heart disease surgery services not provided through CHD, or for kidney services not provided through KRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient*, and *Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.* The Plan does not pay any Benefits for obesity surgery not provided through the BRS program.

SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call to obtain prior authorization.

This section supplements the second table in Section 4, *Plan Highlights.*

While the table in Section 4. *Plan Highlights* provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 7, *Exclusions and Limitations.*

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

Covered Health Services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Acupuncture services will be reviewed after 20 visits for medical necessity.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed services or if goals have previously been met.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 12, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services, please remember that you must obtain prior authorization from the Claims Administrator as soon as possible prior to the transport. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated Provider is defined in Section 12, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by the Claims Administrator or a Personal Health Support Nurse.
- Call CRS at 1-866-936-6002.
- Visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Provider.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Clinical Trials

The Plan pays for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as determined by UnitedHealthcare, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for qualifying Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.

- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*).
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*

- Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgery Services

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD surgery services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the number on your ID card for information about these guidelines.

The Plan pays Benefits for Congenital Heart Disease (CHD) surgery services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD surgery services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD surgery services other than those listed above are excluded from coverage, unless determined by UnitedHealthcare to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive Congenital Heart Disease services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you should contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD surgery services received at a Congenital Heart Disease Resource Services program.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as the possibility of a CHD surgery arises. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Dental Services - Accident Only

Accident only dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within 3 months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for accidental Injury for children. Timing of when the Covered Services will be rendered is determined by the Physician.

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Dental Services – Treatment of a Medical Condition

The Plan covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental treatment required as a result of a medical condition, but which is not an integral component of the treatment of that condition, is not covered (examples include decayed teeth due to dry mouth from medication or disease, or treatment of disease).

Dental Treatment Covered under Plan

The Plan provides Benefits for services provided by a duly licensed doctor, doctor of dental surgery or doctor of dental medicine for diagnostic, therapeutic or surgical procedures, including oral surgery involving bones or joints of the jaw, when the procedure is related to one of the following conditions:

- Congenital deformity, including cleft lip and cleft palate; and
- Removal of:
  - Tumors;
  - cysts which are not related to teeth or associated by dental procedures; and
  - exostoses for reasons other than preparation of dentures.

The Plan provides Benefits for dental implants and related procedures, such as bone grafting associated with the above three conditions.

In addition, Benefits may be provided for dentures and orthodontic braces if used to treat congenital deformity including cleft lip and cleft palate.

When any of the conditions listed above require surgical correction, Benefits for surgery will be subject to a Covered Health Service review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth.

In special cases, Benefits are only provided for anesthesia and facility charges related to dental procedures performed in a hospital or ambulatory surgical center. This Benefit is only available to dependent children below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating provider must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other dental services, including the charge for surgery, are not covered unless specifically covered by the Plan.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items	Insulin pumps and pump supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Diabetic supplies such as monitors, syringes, test strips, and lancets are covered under the Plan's prescription drug benefit.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen;
- Equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- Delivery pumps for tube feedings;
- Breast pumps (only as provided under the *Health Resources and Services Administration* (HRSA) requirement);
- Negative pressure wound therapy pumps (wound vacuums);
- Burn garments;

- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital – Inpatient Stay*, *Rehabilitation Services – Outpatient Therapy* and *Surgery – Outpatient* in this section;
- Orthotic devices when prescribed by Physician. This includes braces that straighten or change the shape of a body part, cranial orthotics (helmets)for correction of positional plagiocephaly, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, shoes/inserts made from a mold of a Covered Person's foot; Charges for custom built orthopedic shoes when medically necessary must be prescribed by a doctor and limited to two (2) pairs per calendar year;
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage;
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every five calendar years.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the five year timeline for replacement.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 2, *How the Plan Works.*

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Please remember that you must notify the Claims Administrator within 48 hours of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency.

Foot Care

The Plan covers hygienic and preventive maintenance foot care; cutting or removal of corns and calluses, nail trimming, cutting, or debriding only if the treatment is a Covered Health Service and related to a medical condition.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in this section.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in this section.

- Cross-sex hormone therapy dispensed from a pharmacy is provided under the Plan's prescription drug benefit.

- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

  - Clitoroplasty (creation of clitoris).
  - Labiaplasty (creation of labia).
  - Orchiectomy (removal of testicles).
  - Penectomy (removal of penis).
  - Urethroplasty (reconstruction of female urethra).
  - Vaginoplasty (creation of vagina).

  Female to Male:

  - Bilateral mastectomy or breast reduction.
  - Hysterectomy (removal of uterus).
  - Metoidioplasty (creation of penis, using clitoris).
  - Penile prosthesis.
  - Phalloplasty (creation of penis).
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries).
  - Scrotoplasty (creation of scrotum).
  - Testicular prosthesis.
  - Urethroplasty (reconstruction of male urethra).
  - Vaginectomy (removal of vagina).
  - Vulvectomy (removal of vulva).

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:

  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Must 18 years or older.

- If significant medical or mental health concerns are present, they must be reasonably well controlled.
- Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Prior Authorization Requirement for Surgical Treatment
You must obtain prior authorization as soon as the possibility of surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category in this section.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 12, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 12, *Glossary* for the definition of Skilled Care.

The Claims Administrator will determine if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Prior Authorization Requirement
You must obtain prior authorization for nutritional foods and skilled nursing, from the Claims Administrator five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
Please remember for Benefits for:
- A scheduled admission, you must obtain prior authorization five business days before admission.

- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) services provided by Designated Providers participating in the Kidney Resource Services (KRS) program. Designated Provider is defined in Section 12, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by the Claims Administrator or Personal Health Support.
- Call KRS at 1-866-561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Provider. If you receive services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography including 3D mammograms (breast tomosynthesis) for screening or diagnosis of breast cancer.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.* Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirement
For Benefits for sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement
For Benefits for sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for Benefits for:

- A scheduled admission for Mental Health Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.

- Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management, you must obtain prior authorization for Benefits before services are received.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember for Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification as soon as is reasonably possible.
- In addition, you must obtain prior authorization for Benefits from the Mental Health/Substance-Related and Addictive Disorders Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout (a form of arthritis).
- Renal failure.
- Phenylketonuria (a genetic disorder diagnosed at infancy).
- Hyperlipidemia (excess of fatty substances in the blood).

Benefits are limited to six individual sessions per calendar year for each medical condition.

Obesity Surgery

(The Plan pays Benefits only for Covered Health Services provided through BRS.)

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician if any of the following are true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea, hypertension, cardiopulmonary condition or diabetes) directly related to, or exacerbated by, obesity.

In addition to meeting the above criteria the following must also be true:

- you have any life threatening or serious medical condition that is weight induced;
- a psychological examination of the Covered Person's readiness and fitness for surgery and the necessary postoperative lifestyle changes has been completed;
- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years;
- you have completed a 6-month Physician supervised weight loss program; and
- you have completed a pre-surgical psychological evaluation.

Coverage of surgical treatment of morbid obesity is limited to adults who are 18 years old or older.

You will have access to a certain Network of Designated Providers participating in the Bariatric Resource Services (BRS) program, as defined in Section 12, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling the toll-free number on the back of your ID card.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with obesity-related services received at a Designated Provider.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 12, *Glossary* and are not Experimental or Investigational or Unproven Services.

Orthotic Devices

Refer to the Durable Medical Equipment (DME) section above for details.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-Ray and Diagnostics - Outpatient.*

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as is reasonably possible before Genetic Testing – BRCA. If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Please Note
Your Physician does not have a copy of your Benefit Booklet, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

If you fail to obtain prior authorization as required, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 6, *Clinical Programs and Services*, for details.

Preventive Care Services

The Plan pays Benefits for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

Examples of preventive care services include routine physical examinations, well-baby and well-child care, immunizations, screening mammograms and prostate screenings. Preventive care Benefits for women defined under the Health Resources and Services Administration

(HRSA) requirement include the cost of renting or purchasing one breast pump per Pregnancy in conjunction with childbirth.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

Preventive care Benefits for women defined under the Health Resources and Services Administration (HRSA) requirement also include the following:

- Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to he at high risk for diabetes;
- Human papillomavirus testing in women with normal cytology results beginning at age 30 and no more frequently than once every three years;
- Annual counseling for sexually transmitted infections;
- Annual counseling and screening for human immune-deficiency virus;
- Comprehensive lactation support and counseling in conjunction with each birth, by a trained provider during pregnancy and/or in the postpartum period;
- All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, as prescribed by a doctor; and
- Annual screening and counseling for interpersonal and domestic violence.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator before obtaining a breast pump that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), as defined in Section 12, *Glossary*.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator for Private Duty Nursing – Outpatient visits. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every five calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are more than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry without regard to the lapse of time between the mastectomy and the reconstructive surgery. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 12, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Prior Authorization Requirement
For Benefits for:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedure is performed.

- A non-scheduled Reconstructive Procedure, you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained from the Claims Administrator as required, or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy;
- Occupational therapy;
- Manipulative/Chiropractic Treatment;
- Speech therapy;
- Post-cochlear implant aural therapy;
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- Pulmonary rehabilitation; and
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- The services are ordered by a Physician and provided and administered by a licensed provider.
- The services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- The services require clinical training in order to be delivered safely and effectively.
- The services are not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders. Rehabilitation services will be reviewed after 40 visits for medical necessity. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Also, other than as described under Habilitative Services above, Physical therapy, Occupational therapy and Post-cochlear implant aural therapy will be reviewed after 40 visits for medical necessity.

Manipulative/Chiropractic Treatment will be reviewed after 20 visits for medical necessity.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient.* Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services.*

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12, *Glossary.*

Any combination of Network Benefits and Non-Network Benefits is limited to 150 days per Covered Person per calendar year.

Prior Authorization Requirement
Please remember, for Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency), you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required or notification is not provided as required, Benefits will be reduced to 50% of Eligible Expenses.

Spine and Joint Solution (SJS) Program MANDATORY

The Spine and Joint Solution (SJS) program is for eligible participants age 18 and older. SJS provides support before, during, and after surgery. Nurses help direct participants to high-quality facilities and provide them case management support.

In-scope procedures include:

- Spine Fusion Inpatient Surgery.
- Disc Inpatient Surgery.
- Total Hip Replacement Inpatient Surgery.
- Total Knee Replacement Inpatient Surgery.

If care involves a hospital admission, it may also require that surgery is performed at an SJS Center of Excellence (COE) facility (Designated Provider). To enroll in the program and find the closest COE provider, call 1-877-214-2930 and ask to speak with an SJS Nurse.

You must enroll in the SJS Program to access benefit coverage for spine and joint procedures. Failure to enroll in the program may result in no coverage for your spine & joint procedure.

Enhanced travel benefits may be available to participants who enroll in this program and utilize a Center of Excellence (COE) facility (Designated Provider) for their eligible surgery. See *Travel and Lodging* for details.

As part of the SJS program, most facilities will cover costs related to complications that result from the surgery for a period of 90 days after the surgery. Claims incurred during this period of time will be reviewed to determine if they were a complication related to the surgery or a readmission to the COE and, as a result, if this feature applies.

Benefits are available for spine and joint services that meet the definition of a Covered Health Service, as defined in Section 12, *Glossary* and are not Experimental or Investigational or Unproven Services.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.

- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/ Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
Please remember, for Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility), you must obtain authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator prior to the admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as soon as is reasonably possible.
- In addition, for Benefits you must obtain prior authorization from the Mental Health/Substance-Related and Addictive Disorders Administrator before the following services are received: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance-related and addictive disorders.

If you fail to obtain prior authorization from or to provide notification to the Mental Health/Substance-Related and Addictive Disorders Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement
For Benefits for sleep apnea surgery, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration (FDA)*-approved TMJ implants only when all other treatment has failed.

Benefits for oral appliances and associated expenses are limited to a $1,500 maximum per Covered Person per lifetime.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MRI guided focused ultrasound.

If you fail to obtain prior authorization from the Claims Administrator, as required, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

The Plan pays Benefits for organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Designated Provider, Network facility that is not a Designated Provider or a non-Network facility.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Provider.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Travel and Lodging Assistance Program

Travel and Lodging assistance is available under the Plan for you or your eligible family member only if you meet the qualifications for the benefit, including receiving care at a Designated Provider that is more than 50 miles from your home address. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.

- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.
- The SJS services program provides a maximum of $2,000 per Covered Person per procedure for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

  The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem rate, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

  Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.

- Taxi fares (not including limos or car services).
- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 12, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section. Benefits under this section are available for services to treat a condition that does not meet the definition of Urgent Care.

Virtual Visits

The Plan provides Benefits for virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Vision Examinations

The Plan pays Benefits for:

- Vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment).
- One routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every calendar year; and
- Non routine vision exam and refraction eye exam – (Vision Exam - medical/surgical eye care is typically problem-oriented, involving the use of medication and/or surgical procedures to diagnose and treat eye problems, such as glaucoma, pink eye and cataracts.

Refractive eye exam – external and internal exam, neurological integrity, pupillary reflexes, versions, biomicroscopy, tonometry, visual acuity, subjective, refraction, accomodative function, binocular function).

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from treatment of malignancy or permanent loss of hair from an accidental injury.

Benefits are limited to a $500 maximum per Covered Person per lifetime.

SECTION 6 - CLINICAL PROGRAMS AND SERVICES

What this section includes:
Health and well-being resources available to you, including:
- Condition Management Services; and
- Telephonic Wellness Coaching.

The Company believes in giving you the tools you need to be an educated health care consumer. To that end, the Company has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and the Company are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that the Company has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drug products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine℠ any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium® Program

To help people make more informed choices about their health care, the UnitedHealth Premium® program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are available when you log onto **www.myuhc.com**;
- search for Network providers available in your Plan through the online provider directory;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information;
- view and print all of your Explanations of Benefits (EOBs) online; and
- order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports Covered Persons who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 5, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS).*

Condition Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a condition management program at no cost to you. The heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition. These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the condition management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate Covered Persons and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 12, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Telephonic Wellness Coaching

The following provides a description of and the eligibility criteria for each Wellness Coaching program:

Tobacco Cessation Program

A tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support throughout the quitting process for up to one year via toll-free phone and live chat.
- Nicotine replacement therapy (patch, lozenge or gum) sent to you in conjunction with your quit date.

- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in the Quit For Life® program, or if you would like additional information regarding the program and also how to access the program online, please call the number on the back of your ID card.

Stress Management Program

UnitedHealthcare's stress management program will provide you with information to help you manage stress through positive behavioral changes.

UnitedHealthcare will identify Covered Persons who are eligible for the stress management program based on the following criteria:

- Covered Persons who feel tense, anxious, or depressed often and stress has had a noticeable impact on health a lot over the past year.

Nutrition Management Program

UnitedHealthcare's nutrition management program will provide you with information designed to increase your awareness of the importance of proper nutrition, and setting dietary goals, and making lifestyle changes. UnitedHealthcare will identify Covered Persons eligible for the nutrition management program based on the following criteria:

- Covered Persons having a BMI of greater than or equal to 25 and less than 30 and 5-6 servings of high cholesterol food per day. BMI greater than or equal to 30 is prioritized to the weight management program.

Exercise Management Program

UnitedHealthcare's exercise management program will provide you with information to assist you in developing an appropriate exercise regime, giving consideration to factors such as age, weight and other health-related conditions. UnitedHealthcare will also provide exercise educational materials. UnitedHealthcare will identify Covered Persons eligible for the exercise management program based on the following criteria:

- Covered Persons with a BMI of greater than or equal to 25 and less than 30 and have physical activity less than one time per week. BMI greater than or equal to 30 is prioritized to the weight management program.

Heart Health Lifestyle Management Program (Blood Pressure/Cholesterol)

The heart health lifestyle management program provides you with an overall understanding of the factors that affect heart health, such as blood pressure and cholesterol. You receive assistance in making lifestyle changes to reduce risks, in addition to guidance on factors that increase risks, such as lack of proper nutrition and exercise. The identification/stratification criteria for the heart health lifestyle management program are as follows:

- self-report excess weight with a BMI > 25; or
- Covered Person has at least one of the following risk criteria:
  - systolic BP = >/=140 or Diastolic BP = ./=90
  - high Blood Pressure and is on medication
  - cholesterol = 240 or HDL < 40
  - indicates has high cholesterol & is on medication
  - high LDL
  - indicates has heart problems, but no heart failure
- BMI greater than or equal to 30 is prioritized to the weight management program.

Diabetes Lifestyle Management Program

The diabetes lifestyle management program is designed to educate you on proper diet, weight loss/management and exercise. You receive educational materials and guidance focused on prevention through diet, weight loss management, exercise and, when applicable, compliance with prescribed medication. The identification/stratification criteria for the diabetes lifestyle management program are as follows:

- Covered Persons who indicate they have diabetes and self-report excess weight with a BMI > 25. BMI greater than or equal to 30 is prioritized to the weight management program.

Wellness Programs

Real Appeal Program

UnitedHealthcare provides the Real Appeal program, which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.

- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325). TTY users can dial 711 or visit **www.realappeal.com**.

Healthy Pregnancy Program

If you are pregnant and enrolled in the Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 7 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:
- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 5, *Additional Coverage Details.*

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 4, *Plan Highlights.* Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 4, *Plan Highlights.* Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the Benefit Booklet says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Benefit Booklet specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing (holistic tissue massage).
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health.*

This exclusion does not apply to Manipulative/Chiropractic Treatment and non-manipulative/chiropractic osteopathic care for which Benefits are provided as described in Section 5, *Additional Coverage Details.*

Dental

1. dental implants or root canals, orthodontic braces, removal of teeth and intra-bony cysts, procedures performed for the preparation of the mouth for dentures, except as identified under Dental Treatment Covered under Plan in Section 5, *Additional Coverage Details.*

2. Treatment for the following conditions:
   - injury related to chewing or biting;
   - preventive dental care, diagnosis or treatment of or related to the teeth or gums;
   - periodontal disease or cavities and disease due to infection or tumor.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement.

For information on your dental coverage, contact your Dental Plan provider.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. The following items are excluded, even if prescribed by a Physician:

   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

3. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

4. The replacement of lost or stolen prosthetic devices;

5. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details;*

6. Oral appliances for snoring;

7. Orthotic appliances and devices that straighten or re-shape a body part, except when prescribed by a Physician as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details.*

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill (See your CVS Caremark Prescription Drug Benefit Booklet for information about the Plan's prescription drug benefit).
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Clomiphine (e.g., Clomid®), menotropins (e.g., Repronex®), or other drugs associated with conception by artificial means.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

2. Treatment of flat feet.

3. Treatment of subluxation of the foot.

4. Arch supports.

Gender Dysphoria

1. Cosmetic Procedures, including the following:

   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.
   - Rhinoplasty.
   - Skin resurfacing.
   - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
   - Voice modification surgery.
   - Voice lessons and voice therapy.

2. Reversal of tubal ligation or vasectomy.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - Compression stockings, ace bandages, diabetic strips, and syringes.

   This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 5, *Additional Coverage Details.*
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details.*

- Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *Additional Coverage Details.*

2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.

4. The replacement of lost or stolen Durable Medical Equipment.

5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 5, *Additional Coverage Details.*

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 7, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 5, *Additional Coverage Details.*

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder.

4. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

7. Transitional Living services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Food of any kind. Foods that are not covered include:

   - nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Food is covered only when the sole source of nutrition and administered via enteral feeding (tube feeding). Infant formula available over the counter is always excluded;
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

3. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement;
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Exercise equipment and treadmills.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Medical alert systems.
   - Motorized beds, non-Hospital beds, comfort beds and mattresses.

- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 12, *Glossary*. Examples include:

   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note**: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Wigs regardless of the reason for the hair loss except for treatment of malignancy or permanent loss of hair from an accidental injury, in which case the Plan pays up to a maximum of $500 per Covered Person per lifetime; and;

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).