UTILIZATION MANAGEMENT (cont.)

- second trimester pregnancy which shall extend through the provision of 60 days of postpartum care; and
- terminal illness which shall extend through the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be paid at the *member's in-network* benefit level. Continuity of care will not be provided when the *provider's* contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal. Please call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for additional information.

Further Review Of *Utilization Management* Decisions

If you receive a *noncertification* as part of the *prior review* process, you have the right to request that the *Plan* review the decision through the *grievance* process. Refer to "What If You Disagree With A Decision?"

Delegated *Utilization Management*

For *UM* and the first level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services, Magellan Behavioral Health is responsible. Claims determinations and second level *grievance* review are provided by BCBSNC.

Evaluating New Technology

In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new medical technology, procedures and equipment. These policies allow BCBSNC to determine the best services and products to offer *members*. They also help BCBSNC keep pace with the ever-advancing medical field. Before implementing any new or revised policies, BCBSNC reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. BCBSNC then seeks additional input from *providers* who know the needs of the patients they serve.

WHAT IF YOU DISAGREE WITH A DECISION?

In addition to the *UM* program, the *Plan* offers a *grievance* procedure for *members*. *Grievances* include dissatisfaction with a claims denial or any decisions (including an appeal of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services. If you have a *grievance*, you have the right to request that BCBSNC review the decision through the *grievance* process. The *grievance* process is voluntary and may be requested by the *member* or an authorized representative acting on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps To Follow In The *Grievance* Process

For each step in this process, there are specified time frames for filing a *grievance* and for notifying you or your *provider* of the decision. The review must be requested in writing, within 180 days of a denial of benefit coverage (the initial claim denial or the first level *grievance* review decision).

Any request for review should include:

- Employee's ID number
- Employee's name
- Any other information that may be helpful for the review.
- Patient's name
- The nature of the *grievance*

To request a form to submit a request for review, visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

All correspondence related to a request for a review through BCBSNC's *grievance* process should be sent to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

In addition, members may also receive assistance with *grievances* from the Managed Care Patient Assistance Program by contacting:

Managed Care Patient Assistance Program
9001 Mail Service Center
Raleigh, NC 27699-9001
Tel: (919) 733-6272
Tel (toll free in NC): 1-866-867-6272
Email: MCPA@ncdoj.gov

Following such request for review, a review will be conducted by BCBSNC, by someone who is neither the individual who made the original claims denial that is the subject of the *grievance*, nor the subordinate of such individual. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations with respect to whether a particular treatment, drug or other item is *experimental, investigational*, or not *medically necessary* or appropriate, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

First Level Grievance Review

BCBSNC will provide you with the name, address and phone number of the *grievance* coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials. For *grievances* concerning quality of health care, an acknowledgement will be sent by BCBSNC within five business days.

Although you are not allowed to attend a first level *grievance* review, BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level *Grievance* Review

Since the *Plan* is subject to *ERISA*, the first level *grievance* review is the only level that you must complete before you can pursue your *grievance* in an action in federal court.

Otherwise, if you are dissatisfied with the first level *grievance* review decision, you have the right to a second level *grievance* review. Second level *grievances* are not allowed for benefits or services that are clearly excluded by this benefit booklet or quality of care complaints. Within ten business days after BCBSNC receives your request for a second level *grievance* review, the following information will be given to you:

- Name, address and telephone number of the *grievance* coordinator
- A statement of your rights, including the right to:

WHAT IF YOU DISAGREE WITH A DECISION? *(cont.)*

- request and receive from BCBSNC all information that applies to your case
- attend the second level *grievance* review meeting
- present your case to the review panel
- submit supporting material before and at the review meeting
- ask questions of any member of the review panel
- be assisted or represented by a person of your choosing, including a family member, an *employer* representative, or an attorney
- pursue other voluntary alternative dispute resolution options.

The second level review meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level *grievance* review request. You will receive notice of the meeting date and location at least 15 days before the meeting. You have the right to a full review of your *grievance* even if you do not attend the meeting. A written decision will be issued to you within five business days of the review meeting.

Notice Of Decision

If any claim (whether expedited or nonexpedited) shall be wholly or partially denied at either the first level *grievance* or the second level *grievance* review, a written notice shall be provided to the *member* worded in an understandable manner and shall set forth:

- The specific reason(s) for the denial
- Reference to the specific the *Plan* provisions on which the decision is based
- A statement that the *member* is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the *member's* claim for benefits
- If applicable, a statement describing any voluntary appeals procedures and the *member's* right to receive information about the procedures as well as the *member's* right to bring a civil action under Section 502(a) of *ERISA* following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request
- If the decision is based on *medical necessity* or *experimental* treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *member's* medical circumstances, or a statement that such explanation will be provided without charge upon request; and
- The following statement: "You 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."

Expedited Review

You have the right to a more rapid or expedited review of a denial of coverage if a delay: (i) would reasonably appear to seriously jeopardize your or your dependent's life, health or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling BCBSNC Customer Service at the number given in "Whom Do I Call?" An expedited review will take place in consultation with a medical *doctor*. All of the same conditions for a first level or second level *grievance* review apply to an expedited review, except that the review meeting will take place through a conference call or through written communication. BCBSNC will communicate the decision by phone to you and your *provider* as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

After requesting an expedited review, the *Plan* will remain responsible for covered health care services you are receiving until you have been notified of the review decision.

Correspondence related to a request for a review through the *Plan's grievance* process should be sent to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

Delegated Appeals

Magellan Behavioral Health is responsible for the first level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services. Please forward written *grievances* to:

Magellan Behavioral Health
Appeals Department
PO Box 1619

WHAT IF YOU DISAGREE WITH A DECISION? *(cont.)*

Alpharetta, GA 30009
Second level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services is provided by BCBSNC.

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits To Which *Members* Are Entitled

The benefits described in this benefit booklet are provided only for *members*. These benefits and the right to receive payment cannot be transferred to another person. At the option of the *Plan*, payment for services will be made to the *provider* of the services, or the *Plan* may choose to pay the *participant*.

If a *member* resides with a custodial parent or legal guardian who is not the *participant*, the *Plan* will, at its option, make payment to either the *provider* of the services or to the custodial parent or legal guardian for services provided to the *member*. If the *participant* or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the *provider*.

Benefits for *covered services* specified in the *Plan* will be provided only for services and supplies that are performed by a *provider* as specified in the *Plan* and regularly included in the *allowed amount*. BCBSNC establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under the *Plan*.

Any amounts paid by the *Plan* for noncovered services or that are in excess of the benefit provided under your Blue Options coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a *member's* future claim payment. This can result in a reduction or elimination of future claims payments. Amounts paid by the *Plan* for work-related accidents, injuries, or illnesses covered under state workers' compensation laws will be recovered upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the *member*, the employer or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

Providers are independent contractors, and they are solely responsible for injuries and damages to *members* resulting from misconduct or negligence.

BCBSNC's Disclosure Of Protected Health Information (PHI)

BCBSNC takes your privacy seriously and handles all PHI as required by state and federal laws and regulations and accreditation standards. BCBSNC has developed a privacy notice that explains the procedures. To obtain a copy of the privacy notice, visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Administrative Discretion

BCBSNC has the authority to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning coverage of services, care, treatment or supplies, and reasonableness of charges. BCBSNC medical policies are guides considered when making coverage determinations.

Provider Reimbursement

BCBSNC has contracts with certain *providers* of health care services for the provision of, and payment for, health care services provided to all *members* entitled to health care benefits. BCBSNC's payment to *providers* may be based on an amount other than the actual charges, including without limitation, an amount per confinement or episode of care, agreed upon schedule of fees, or other methodology as agreed upon by BCBSNC and the *provider*. Under certain circumstances, a contracting *provider* may receive payments from BCBSNC greater than the charges for services provided to an eligible *member*, or BCBSNC may pay less than charges for services, due to negotiated contracts. The *member* is not entitled to receive any portion of the payments made under the terms of contracts with *provider*. The *member's* liability when defined as a percent of charge shall be calculated based on the lesser of the *allowed amount* or the *provider's* actual charge for *covered services* provided to a *member*.

Services Received In North Carolina

Some *out-of-network providers* have other agreements with BCBSNC that affect their reimbursement for *covered services* provided to Blue Options *members*. These *providers* agree not to bill *members* for any charges higher than their agreed upon, contracted amount. In these situations, *members* will be responsible for the difference between the Blue Options *allowed amount* and the contracted amount. *Out-of-network providers* may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

Services Received Outside Of North Carolina

Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the BlueCard program. Your *ID card* tells participating *providers* that you are a *member* of BCBSNC. By taking part in this program, you may receive discounts from out-of-state *providers* who participate in the BlueCard program.

When you obtain health care services through the BlueCard program outside the area in which the BCBSNC network operates, the amount you pay toward such *covered services*, such as *deductibles*, *copayments* or *coinsurance*, is usually based on the **lesser** of:

- The billed charges for your *covered services*, or
- The negotiated price that the out-of-state Blue Cross and/or Blue Shield licensee ("Host Blue") passes on to BCBSNC.

This "negotiated price" can be:

- A simple discount which reflects the actual price paid by the Host Blue
- An estimated price that factors in expected settlements, withholds, contingent payment arrangements, or other nonclaims transactions, with your health care *provider* or with a group of *providers*

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

- A discount from billed charges that reflects the **average** expected savings with your health care *provider* or with a group of *providers*. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

The estimated or average price may be adjusted in the future to correct for over- or under-estimation of past prices. However, the amount you pay is considered a final price.

Should any state enact a law that mandates liability calculation methods that differ from the usual BlueCard program method or requires a surcharge, your required payment for services in that state will be based upon the method required by that state's law.

Right Of Recovery Provision

Immediately upon paying or providing any benefit under the *Plan*, the *Plan* shall be subrogated to all rights of recovery a *member* has against any party potentially responsible for making any payment to a *member* due to a *member's* injuries, illness or condition, to the full extent of benefits provided or to be provided by the *Plan*.

In addition, if a *member* receives any payment from any potentially responsible party as a result of an injury, illness or condition, the *Plan* has the right to recover from, and be reimbursed by, the *member* for all amounts the *Plan* has paid and will pay as a result of that injury or illness, up to and including the full amount the *member* receives from all potentially responsible parties. The *member* agrees that if the *member* receives any payment from any potentially responsible party as a result of an injury or illness, the *member* will serve as a constructive trustee over the funds for the benefit of the *Plan*. Failure to hold such funds in trust will be deemed a breach of the *member's* fiduciary duty to the *Plan*.

Further, the *Plan* will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a *member* receives from any third party, any third party's insurer or any other source as a result of the *member's* injuries. The lien is in the amount of benefits paid by the *Plan* for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a *member* due to a *member's* injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The lien can be filed with or enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the *Plan* including, but not limited to, the *member*, the *member's* representative or agent; responsible party; responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the *Plan*.

The *member* acknowledges that the *Plan's* recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the *Plan* before any other claim for the *member's* damages. The *Plan* shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the *Plan* will result in a recovery to the *member* which is insufficient to make the *member* whole or to compensate the *member* in part or in whole for the damages sustained. It is further understood that the *Plan* will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the *Plan* is not required to participate in or pay court costs or attorney fees to any attorney hired by the *member*.

The terms of this entire right of recovery provision shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the *member* identifies the medical benefits the *Plan* provided. The *Plan* is entitled to recover from **any and all** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The *member* acknowledges that BCBSNC has been delegated authority by the *Plan Administrator* to assert and pursue the right of subrogation and/or reimbursement on behalf of the *Plan*. The *member* shall fully cooperate with BCBSNC's efforts to recover benefits paid by the *Plan*. It is the duty of the *member* to notify BCBSNC in writing of the *member's* intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the *member*. The *member* shall provide all information requested by BCBSNC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as BCBSNC may reasonably request.

The *member* shall do nothing to prejudice the *Plan's* recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by the *Plan*.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the *member* and the *Plan* agree that the *Plan Administrator* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The *member* agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as BCBSNC may elect. Upon receiving benefits under the *Plan*, the *member* hereby submits to each such jurisdiction, waiving whatever rights may correspond to the *member* by reason of the *member's* present or future domicile.

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

Notice Of Claim

The *Plan* will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that *covered services* have been provided to a *member*. If the *member* files the claim, written notice must be given to BCBSNC within 18 months after the *member incurs* the *covered service*, except in the absence of legal capacity of the *member*. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

Notice Of Benefit Determination

BCBSNC will provide an explanation of benefits determination to the *member* or the *member's* authorized representative within 30 days of receipt of a notice of claim if the *member* has financial liability on the claim other than a *copayment* (unless your *Plan* has chosen to provide an explanation of benefits for additional claims where the *member* does not have a financial liability other than a *copayment*). BCBSNC may take an extension of up to 15 additional days to complete the benefits determination if additional information is needed. If BCBSNC takes an extension, BCBSNC will notify the *member* or the *member's* authorized representative of the extension and of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days.

Such notice will be worded in an understandable manner and will include:

- The specific reason(s) for the denial of benefits
- Reference to the benefit booklet section on which the denial of benefits is based
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed
- A description of the review procedures and the time limits applicable to such procedures, including the *member's* right to bring a civil action under Section 502(a) of *ERISA* following a denial of benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request
- If the denial of benefits is based on *medical necessity* or *experimental* treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the health benefit plan to the *member's* medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of a denial of benefits involving *urgent care*, a description of the expedited review process available to such claims.

Upon receipt of a denial of benefits, you have the right to file a *grievance* with BCBSNC. See "What If You Disagree With A Decision?" for more information.

Limitation Of Actions

Since the *Plan* is subject to *ERISA*, you must only exhaust the first level *grievance* review process following the Notice of Claim requirement. Please see "What If You Disagree With A Decision?" for details regarding the *grievance* review process. No legal action may be taken later than three years from the date *covered services* are *incurred*. However, if you are authorized to pursue an action in federal court under *ERISA*, and you choose to pursue a second level *grievance* review, the three-year limitation is temporarily suspended until that review has been resolved.

Coordination Of Benefits (Overlapping Coverage)

If a *member* is also enrolled in another group health plan, the *Plan* may coordinate benefits with the other plan. Coordination of benefits (COB) means that if a *member* is covered by more than one insurance plan, benefits under one plan are determined before the benefits are determined under the second plan. The plan that determines benefits first is called the primary plan. The other plan is called the secondary plan. Benefits paid by the secondary plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service.

Most group health insurance plans include a COB provision. The rules used to determine which plan is primary and secondary are listed in the following chart. The "participant" is the person who is signing up for health insurance coverage.

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	Yes	
	The plan with COB is		Yes
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	Yes	
	The plan covering the person as a dependent is		Yes
The person is covered as a dependent child under both plans, including when parents are divorced or separated and share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	Yes	
	The plan of the parent whose birthday is later in the calendar year is		Yes
	Note: When the parents have the same birthday, the plan that covered the parent longer is	Yes	
The person is covered as a dependent child and parents are divorced or separated with no court decree for coverage	The custodial parent's plan is	Yes	
	The plan of the spouse of the custodial parent is		Yes
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	Yes	
	The non-custodial parent's plan is		Yes
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	Yes	
	The plan of the other parent is		Yes
	Note: If there is a court decree that requires a parent to assume financial responsibility for the child's health care coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent's health benefit plan are	Yes	
The person is covered as a laid-off or retired employee or that employee's dependent, on one of the plans	The plan that covers a person other than as a laid-off or retired employee or as that employee's dependent	Yes	
	The plan that covers a person as a laid-off or retired employee or the dependent of a laid-off or retired employee		Yes
	Note: This rule does not apply if it results in a conflict in determining order of benefits		
The person is the participant in two active group health plans and none of the rules above apply	The plan that has been in effect longer is	Yes	
	The plan that has been in effect the shorter amount of time is		Yes

NOTE: Payment by BCBSNC under the *Plan* takes into account whether or not the *provider* is a participating *provider*. If the *Plan* is the secondary plan, and the *member* uses a participating *provider*, the *Plan* will coordinate up to the *allowed amount*. The participating *provider* has agreed to accept the *allowed amount* as payment in full.

BCBSNC may request information about the other plan from the *member*. A prompt reply will help BCBSNC process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits are coordinated with other group health plans, benefits for *covered services* are still subject to program requirements, such as *prior review* and *certification* procedures.

DEFINITIONS

ALLOWED AMOUNT — the charge that BCBSNC determines is reasonable for *covered services* provided to a *member*. This may be established in accordance with an agreement between the *provider* and BCBSNC. In the case of *providers* that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the *provider's* actual charge or a reasonable charge established by BCBSNC using a methodology that is applied to comparable *providers* for similar services under a similar plan. BCBSNC's methodology is based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the *provider* may be combined into one procedure for reimbursement purposes.

AMBULANCE — transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured, includes ground and aircraft.

AMBULATORY SURGICAL CENTER — a *nonhospital facility* with an organized staff of *doctors*, which is licensed or certified in the state where located, and which:

a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an *outpatient* basis
b) Provides nursing services and treatment by or under the supervision of *doctors* whenever the patient is in the facility
c) Does not provide *inpatient* accommodations
d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a *doctor* or *other provider*.

BENEFIT PERIOD — the period of time, as stated in the "Summary Of Benefits," during which charges for *covered services* provided to a *member* must be *incurred* in order to be eligible for payment by the *Plan*. A charge shall be considered *incurred* on the date the service or supply was provided to a *member*.

BENEFIT PERIOD MAXIMUM — the maximum amount of charges for *covered services* in a *benefit period* that will be reimbursed on behalf of a *member* while covered under the *Plan*.

CERTIFICATION — the determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy BCBSNC's requirements for *medically necessary* services and supplies, appropriateness, health care setting, level of care and effectiveness.

COINSURANCE — the sharing of charges by the *Plan* and the *member* for *covered services* received by a *member*, usually stated as a percentage of the *allowed amount*.

COINSURANCE MAXIMUM — the maximum amount of *coinsurance* that a *member* is obligated to pay for *covered services* per *benefit period*.

COMPLICATIONS OF PREGNANCY — medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated prior to the full term of the pregnancy (except as otherwise stated below), including, but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. *Emergency* cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as a complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy.

CONGENITAL — existing at, and usually before, birth referring to conditions that are apparent at birth regardless of their causation.

COPAYMENT — the fixed-dollar amount that is due and payable by the *member* at the time a *covered service* is provided.

COSMETIC — to improve appearance. This does not include restoration of physiological function resulting from accidental injury, trauma or previous treatment that would be considered a *covered service*. This also does not include reconstructive *surgery* to correct *congenital* or developmental anomalies that have resulted in functional impairment.

COVERED SERVICE(S) — a service, drug, supply or equipment specified in this benefit booklet for which *members* are entitled to benefits in accordance with the terms and conditions of the *Plan*.

CREDITABLE COVERAGE — accepted health insurance coverage carried prior to BCBSNC coverage can be group health insurance, self-funded plans, individual health insurance, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as creditable coverage under state or federal law. Creditable coverage does not include coverage consisting solely of excepted benefits.

CUSTODIAL CARE — care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by BCBSNC without regard to the place of service or the *provider* prescribing or providing the services.

DEDUCTIBLE — the specified dollar amount for certain *covered services* that the *member* must incur before benefits are payable for the remaining *covered services*. The deductible does not include *copayments*, *coinsurance*, charges in excess of the *allowed amount*, amounts exceeding any maximum and expenses for noncovered services.

DEFINITIONS *(cont.)*

DENTAL SERVICE(S) — dental care or treatment provided by a *dentist* or *other professional provider* in the *dentist's* office to a covered *member* while the policy is in effect, provided such care or treatment is recognized by BCBSNC as a generally accepted form of care or treatment according to prevailing standards of dental practice.
DENTIST — a dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide *dental services*, perform dental *surgery* or administer anesthetics for dental *surgery*. All services performed must be within the scope of license or certification to be eligible for reimbursement.
DEVELOPMENTAL DYSFUNCTION — difficulty in acquiring the activities of daily living including, but not limited to, walking, talking, feeding or dressing oneself or learning in school. Developmental therapies are those to facilitate or promote the development of skills, which the *member* has not yet attained. Examples include, but are not limited to: speech therapy to teach a *member* to talk, follow directions or learn in school; physical therapy to treat a *member* with low muscle tone or to teach a *member* to roll over, sit, walk or use other large muscle skills; occupational therapy to teach a *member* the activities of daily living, to use small muscle skills or balance or to assist with behavior or achievement in the learning setting.
DOCTOR — includes the following: a doctor of medicine, a doctor of osteopathy, licensed to practice medicine or *surgery* by the Board of Medical Examiners in the state of practice, a doctor of dentistry, a doctor of podiatry, a doctor of chiropractic, a doctor of optometry, or a doctor of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner or scope of practice. All services performed must be within the scope of license or certification to be eligible for reimbursement.
DURABLE MEDICAL EQUIPMENT — items designated by BCBSNC which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home.
EFFECTIVE DATE — the date on which coverage for a *member* begins, according to "When Coverage Begins And Ends."
EMERGENCY(IES) — the sudden or unexpected onset of a condition of such severity 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 an individual or with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock, and other severe, acute conditions are examples of emergencies.
EMERGENCY SERVICES — health care items and services furnished or required to screen for or treat an *emergency* medical condition until the condition is *stabilized*, including pre-hospital care and ancillary services routinely available in the emergency department.
EMPLOYER — Duke Energy Corporation or an affiliated company that is participating in the *Plan*.
ERISA — the Employee Retirement Income Security Act of 1974.
EXPERIMENTAL — see *Investigational*.
FACILITY SERVICES — *covered services* provided and billed by a *hospital* or *nonhospital facility*. All services performed must be within the scope of license or certification to be eligible for reimbursement.
GRIEVANCE — grievances include dissatisfaction with a claims denial or any decisions (including an appeal of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services.
HOLISTIC MEDICINE — unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any *other provider*.
HOMEBOUND — a *member* who cannot leave their home or temporary residence due to a medical condition which requires both the assistance of another person and the aid of supportive devices or the use of special transportation. A *member* is not considered homebound solely because the assistance of another person is required to leave the home.
HOME HEALTH AGENCY — a *nonhospital facility* which is primarily engaged in providing home health care services medical or therapeutic in nature, and which:
a) Provides skilled nursing and other services on a visiting basis in the *member's* home,
b) Is responsible for supervising the delivery of such services under a plan prescribed by a *doctor*,
c) Is accredited and licensed or certified in the state where located,
d) Is certified for participation in the Medicare program, and
e) Is acceptable to BCBSNC.
HOSPICE — a *nonhospital facility* that provides medically related services to persons who are terminally ill, and which:
a) Is accredited, licensed or certified in the state where located,
b) Is certified for participation in the Medicare program, and
c) Is acceptable to BCBSNC.
HOSPITAL — an accredited institution for the treatment of the sick that is licensed as a hospital by the appropriate state agency in the state where located. All services performed must be within the scope of license or certification to be eligible for reimbursement.
IDENTIFICATION CARD (ID card) — the card issued to *members* upon enrollment which provides *employer/member* identification numbers, names of the *members*, applicable *copayments* and/or *coinsurance*, and key phone numbers and addresses.

DEFINITIONS *(cont.)*

INCURRED — the date on which a *member* receives the service, drug, equipment or supply for which a charge is made.
INFERTILITY — the inability of a heterosexual couple to conceive a child after 12 months of unprotected male/female intercourse.
IN-NETWORK — designated as participating in the Blue Options network. BCBSNC's payment for in-network *covered services* is described in this benefit booklet as in-network benefits or in-network benefit levels.
IN-NETWORK PROVIDER — a *hospital, doctor*, other medical practitioner or *provider* of *medical services* and supplies that has been designated as a Blue Options *provider* by BCBSNC or a *provider* participating in the BlueCard program.
INPATIENT — pertaining to services received when a *member* is admitted to a *hospital* or *nonhospital facility* as a registered bed patient for whom a room and board charge is made.
INVESTIGATIONAL (EXPERIMENTAL) — the use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, drug, or device that BCBSNC does not recognize as standard *medical care* of the condition, disease, illness, or injury being treated. The following criteria are the basis for BCBSNC's determination that a service or supply is investigational:

a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply
c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
d) The service or supply under consideration is not as beneficial as any established alternatives
e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

If a service or supply meets one or more of the criteria, it is deemed investigational except for clinical trials as described under the *Plan*. Determinations are made solely by BCBSNC after independent review of scientific data. Opinions of experts in a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered by BCBSNC but are not determinative or conclusive.
LICENSED PRACTICAL NURSE (LPN) — a nurse who has graduated from a formal practical nursing education program and is licensed by the appropriate state authority.
LIFETIME MAXIMUM — the maximum amount of *covered services* that will be reimbursed on behalf of a *member* while covered under the *Plan*.
MAINTENANCE THERAPY — services that preserve your present level of function or condition and prevent regression of that function or condition. Maintenance begins when the goals of the treatment plan have been achieved and/or when no further progress is apparent or expected to occur.
MEDICAL CARE/SERVICES — professional services provided by a *doctor* or *other provider* for the treatment of an illness or injury.
MEDICAL SUPPLIES — health care materials that include ostomy supplies, catheters, oxygen and diabetic supplies.
MEDICALLY NECESSARY (or MEDICAL NECESSITY) — those *covered services* or supplies that are:

a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under the *Plan*, not for *experimental, investigational*, or *cosmetic* purposes,
b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms,
c) Within generally accepted standards of *medical care* in the community, and
d) Not solely for the convenience of the insured, the insured's family, or the *provider*.

For medically necessary services, BCBSNC may compare the cost-effectiveness of alternative services, settings or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.
MEMBER — an *participant* or dependent, who is currently enrolled in the *Plan* and for whom premium is paid.
MENTAL ILLNESS — mental disorders, psychiatric illnesses, mental conditions and psychiatric conditions (whether organic or non-organic, whether of biological, nonbiological, chemical or nonchemical origin and irrespective of cause, basis or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC.)
NONCERTIFICATION — a determination by BCBSNC that a service covered under the *Plan* has been reviewed and does not meet BCBSNC's requirements for *medical necessity*, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of *emergency services* and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is *experimental, investigational* or *cosmetic* is considered a noncertification. A noncertification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

DEFINITIONS *(cont.)*

NONHOSPITAL FACILITY — an institution or entity other than a *hospital* that is accredited and licensed or certified in the state where located to provide *covered services* and is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OFFICE VISIT — *medical care, surgery,* diagnostic services, *short-term rehabilitative therapy* services and *medical supplies* provided in a *provider's* office.

OTHER PROFESSIONAL PROVIDER — a person or entity other than a *doctor* who is accredited and licensed or certified in the state where located to provide *covered services* and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER PROVIDER — an institution or entity other than a *doctor* or *hospital,* which is accredited and licensed or certified in the state where located to provide *covered services* and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER THERAPY(IES) — the following services and supplies, both *inpatient* and *outpatient,* ordered by a *doctor* or *other provider* to promote recovery from an illness, disease or injury when provided by a *doctor, other provider* or professional employed by a *provider* licensed in the state of practice.

a) Cardiac rehabilitative therapy — reconditioning the cardiovascular system through exercise, education, counseling and behavioral change
b) Chemotherapy (including intravenous chemotherapy) — the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the Food and Drug Administration (FDA)
c) Dialysis treatments — the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis
d) Pulmonary therapy — programs that combine exercise, training, psychological support and education in order to improve the patient's functioning and quality of life
e) Radiation therapy — the treatment of disease by x-ray, radium, or radioactive isotopes
f) Respiratory therapy — introduction of dry or moist gases into the lungs for treatment purposes.

OUT-OF-NETWORK — not designated as participating in the Blue Options network, and not certified in advance by BCBSNC to be considered as *in-network*. Payment for out-of-network *covered services* is described in this benefit booklet as out-of-network benefits or out-of-network benefit levels.

OUT-OF-NETWORK PROVIDER — a *provider* that has not been designated as a Blue Options *provider* by BCBSNC.

OUTPATIENT — pertaining to services received from a *hospital* or *nonhospital facility* by a *member* while not an *inpatient*.

OUTPATIENT CLINIC(S) — an accredited institution/facility associated with or owned by a *hospital*. An outpatient clinic may bill for *outpatient* visits, including professional services and ancillary services, such as diagnostic tests. These services may be subject to the *Outpatient* Services benefit. All services performed must be within the scope of the professional or facility license or certification to be eligible for reimbursement.

PARTICIPANT — a person who is eligible for coverage under the *Plan* and properly enrolled.

PLAN — Duke Energy Medical Plan's Preferred Provider Organization (PPO) option.

PLAN ADMINISTRATOR — Duke Energy Benefits Committee.

PLAN SPONSOR — Duke Energy Corporation.

POSITIONAL PLAGIOCEPHALY — the asymmetrical shape of an infant's head due to uneven external pressures on the skull in either the prenatal or postnatal environment. This does not include asymmetry of an infant's head due to premature closure of the sutures of the skull.

PREVENTIVE CARE — *medical services* provided by or upon the direction of a *doctor* or *other provider* related to the prevention of disease.

PRIMARY CARE PROVIDER (PCP) — an *in-network provider* who has been designated by BCBSNC as a PCP.

PRIOR REVIEW — the consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of *medical necessity* of services and supplies, appropriateness, health care setting, or level of care and effectiveness. Prior review results in *certification* or *noncertification* of benefits.

PROSTHETIC APPLIANCES — fixed or removable artificial limbs or other body parts, which replace absent natural ones following permanent loss of the body part.

PROVIDER — a *hospital, nonhospital facility, doctor,* or *other provider,* accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification. All services performed must be within the scope of license or certification to be eligible for reimbursement.

REGISTERED NURSE (RN) — a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program), and is licensed by the appropriate state authority in the state of practice.

ROUTINE FOOT CARE — hygiene and preventive maintenance such as trimming of corns, calluses or nails that do not usually require the skills of a qualified *provider* of foot care services.

SEXUAL DYSFUNCTION — any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

SHORT-TERM REHABILITATIVE THERAPY — services and supplies both *inpatient* and *outpatient,* ordered by a *doctor* or *other provider* to promote the recovery of the *member* from an illness, disease or injury when provided by a *doctor, other*

DEFINITIONS *(cont.)*

provider or professional employed by a *provider* licensed by the appropriate state authority in the state of practice and subject to any licensure or regulatory limitation as to location, manner or scope of practice.

a) Occupational therapy — treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role after such ability has been impaired by disease, injury or loss of a body part
b) Physical therapy — treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part
c) Speech therapy — treatment for the restoration of speech impaired by disease, *surgery*, or injury; or certain significant physical *congenital* conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

SKILLED NURSING FACILITY — a *nonhospital facility* licensed under state law that provides skilled nursing, rehabilitative and related care where professional *medical services* are administered by a registered or *licensed practical nurse*. All services performed must be within the scope of license or certification to be eligible for reimbursement.

SPECIALIST — a *doctor* who is recognized by BCBSNC as specializing in an area of medical practice.

STABILIZE — to provide *medical care* that is appropriate to prevent a material deterioration of the *member's* condition, within reasonable medical certainty.

SURGERY — the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures, such as:

a) The correction of fractures and dislocations
b) Usual and related pre-operative and post-operative care
c) Other procedures as reasonable and approved by BCBSNC.

TRANSPLANTS — the surgical transfer of a human organ or tissue taken from the body for grafting into another area of the same body or into another body; the removal and return into the same body or transfer into another body of bone marrow or peripheral blood stem cells. Grafting procedures associated with reconstructive *surgery* are not considered transplants.

URGENT CARE — services provided for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis or treatment, such that in the absence of immediate care the individual could reasonably be expected to suffer chronic illness, prolonged impairment, or require a more hazardous treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

UTILIZATION MANAGEMENT (UM) — a set of formal processes that are used to evaluate the *medical necessity*, quality of care, cost-effectiveness and appropriateness of many health care services, including procedures, treatments, medical devices, *providers* and facilities.

WAITING PERIOD — the amount of time that must pass before a *member* is eligible to be covered for benefits under the terms of the *Plan*.

BlueCross BlueShield of North Carolina

MEMBER'S AUTHORIZATION REQUEST FORM
COMMERCIAL OPERATIONS / IDC

You may give Blue Cross and Blue Shield of North Carolina (BCBSNC) written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that BCBSNC communicates with members or subscribers. *For example, we will send explanation of benefits (EOB) statements to the subscriber.***

MEMBER WHOSE INFORMATION WILL BE DISCLOSED:

MEMBER'S FIRST NAME | M.I. | MEMBER'S LAST NAME

MONTH / DAY / YEAR — MEMBER'S DATE OF BIRTH

PREFIX | 9 DIGIT IDENTIFIER | SUFFIX — SUBSCRIBER ID NUMBER *(FROM YOUR ID CARD)*

At my request, I authorize BCBSNC to disclose Protected Health Information to *(enter name of person/entity who will receive member's PHI)*:

FIRST NAME | M.I. | LAST NAME

RELATIONSHIP TO MEMBER:

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: **(i)** your subscriber ID number, **(ii)** your date of birth, and **(iii)** subscriber address.

I authorize BCBSNC to disclose the following PHI to the person/entity listed above. CHECK ONLY BOXES THAT APPLY:

☐ ALL Information Requested ☐ Enrollment Information ☐ Benefit Information ☐ Premium Payment Information ☐ Explanation of Benefits (EOB) Information

☐ All Claims Information ☐ All Services from a Specific Health Care Provider(s) *(List Provider's Name)*: _____

☐ Other *(Please List Specific PHI and/or Date Ranges)*: _____

If you want to authorize someone to have access to your mental health or substance abuse PHI, please call the mental health/substance abuse company's telephone number on the back of your membership card to request a separate authorization form from them.

NOTE: BCBSNC will consider the effective date of this authorization to be the date BCBSNC enters this authorization into its Commercial Operations business system, typically five (5) days following receipt.

If you would like this authorization to become effective on a date after BCBSNC enters the authorization into its system, please insert the date here: → MONTH / DAY / YEAR

I would like this authorization to expire on *(enter date)*: MONTH / DAY / YEAR **OR** ☐ **When my policy expires.**

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)

I understand that I may revoke this authorization at any time by giving BCBSNC written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will not affect any action BCBSNC took in reliance on this authorization before BCBSNC received my written notice of revocation.

I also understand that BCBSNC will not condition the provision of health plan benefits on this authorization.

I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature: _____ Today's Date: MONTH / DAY / YEAR

If signed by an individual other than the member: _____
PRINT YOUR FULL NAME

Describe your authority to act for the member *(e.g., power of attorney, court order, parent of minor child, etc.)*:

NOTE: Please attach the legal document naming you as the personal representative if you have not previously submitted it to us.

RETURN THIS AUTHORIZATION TO: Commercial Operations / IDC
Blue Cross and Blue Shield of North Carolina
P.O. Box 2291 • Durham, NC 27702-2291

U2516. 1/04

SUMMARY OF BENEFITS

This section provides a summary of your Blue Options benefits. A more complete description of your benefits is found in "*Covered Services.*" General exclusions may also apply — please see "What Is Not Covered?" As you review the "Summary Of Benefits" chart, keep in mind:

- Services subject to a *copayment* are not subject to *deductible* and *coinsurance*
- *Copayment* amounts are fixed dollar amounts the *member* must pay for some *covered services*
- Multiple *office visits* or emergency room visits on the same day may result in multiple *copayments*
- *Coinsurance* percentages shown in this section are the portion of the *allowed amount* that the *Plan* covers
- *Deductible* and *coinsurance* amounts are based on the *allowed amount*
- Services applied to the *deductible* also count toward any visit or day maximums
- To receive *in-network* benefits, you must receive care from a Blue Options *in-network provider*. **However, in an *emergency*, or when *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, you may also receive *in-network* benefits for care from an *out-of-network provider*. Please see "*Out-Of-Network* Benefits" and "*Emergency* Services" for additional information. Access to care standards are available on the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or by calling BCBSNC Customer Service at the number listed on your *ID Card* or in "Whom Do I Call?"**
- If you see an *out-of-network provider*, you will receive *out-of-network* benefits unless otherwise approved by BCBSNC.

Please note: The list of *in-network providers* may change from time to time, so please verify that the *provider* is still in the Blue Options network before receiving care. Find a *provider* on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed on your *ID card* or in "Whom Do I Call?"

SPECIAL NOTICE IF YOU CHOOSE AN *OUT-OF-NETWORK PROVIDER*

NOTICE: Your actual expenses for *covered services* may exceed the stated *coinsurance* percentage or *copayment* amount because actual *provider* charges may not be used to determine the *Plan's* and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount*, in addition to any *copayment* or *coinsurance* amount.

Benefit period January 1 through December 31

Benefit payments are based on where services are received and how services are billed.

	In-network	*Out-of-network*
Physician Office Services		
See *Outpatient* Services for *outpatient clinic* or *hospital*-based services. *Office visits* for the evaluation and treatment of obesity are limited to a combined in- and *out-of-network* maximum of four visits per *benefit period*.		
Office Services		
Primary Care Provider	$40 *copayment*	$40 *copayment*
Specialist	$50 *copayment*	$50 *copayment*
Includes office *surgery*, x-rays and lab tests.		
CT Scans, MRIs, MRAs and PET Scans	80% after *deductible*	80% after *deductible*
Preventive Care		
Primary Care Provider	$40 *copayment*	$40 *copayment*
Specialist	$50 *copayment*	$50 *copayment*
Includes routine physical exams, well baby, well-child care, immunizations, gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests (PSAs).		

SUMMARY OF BENEFITS *(cont.)*

	In-network	*Out-of-network*
Physician Office Services (con't)		
Short-term Rehabilitative Therapies	$50 *copayment*	$50 *copayment*
Chiropractic Services	$50 *copayment*	$50 *copayment*
Combined in- and *out-of-network benefit period maximums* apply to home, office and *outpatient* settings. 80 visits per *benefit period* for speech therapy, physical/occupational therapy, and chiropractic services combined.		
Other Therapies	100%	100%
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See *Outpatient* Services for *other therapies* provided in an *outpatient* setting.		
***Infertility* and *Sexual Dysfunction* Services**		
Primary Care Provider	$40 *copayment*	$40 *copayment*
Specialist	$50 *copayment*	$50 *copayment*
Routine Eye Exam	$50 *copayment*	$50 *copayment*
***Urgent Care* Centers and Emergency Room**		
***Urgent Care* Centers**	$50 *copayment*	$50 *copayment*
Emergency Room Visit	$75 *copay*, then 80% after *deductible*	$75 *copay*, then 80% after *deductible*
If admitted to the *hospital* from the emergency room, *inpatient hospital* benefits apply to all *covered services* provided. If held for observation, *outpatient* benefits apply to all *covered services* provided. If you are sent to the emergency room from an *urgent care* center, you may be responsible for both the emergency room *coinsurance* and the *urgent care copayment*.		
Ambulatory Surgical Center	80% after *deductible*	80% after *deductible*
***Outpatient* Services**		
Physician Services	80% after *deductible*	80% after *deductible*
***Hospital* and *Hospital*-based Services**	80% after *deductible*	80% after *deductible*
***Outpatient Clinic* Services**	80% after *deductible*	80% after *deductible*
***Outpatient* Diagnostic Services:**		
Outpatient lab tests and mammography, when performed alone	100%	100%
Outpatient lab tests and mammography, when performed with another service	80% after *deductible*	80% after *deductible*
Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	80% after *deductible*	80% after *deductible*
CT scans, MRIs, MRAs and PET scans	80% after *deductible*	80% after *deductible*
Therapy Services	80% after *deductible*	80% after *deductible*
Includes *short-term rehabilitative therapies* and *other therapies* including dialysis; see Physician Office Services for visit maximums.		

SUMMARY OF BENEFITS *(cont.)*

	In-network	*Out-of-network*
***Inpatient Hospital* Services**		
Physician Services	80% after *deductible*	80% after *deductible*
***Hospital* and *Hospital*-based Services**	80% after *deductible*	80% after *deductible*

Includes maternity delivery, prenatal and post-delivery care. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new *deductible* for *covered services* from *doctors* or *other professional providers*.

Skilled Nursing Facility	80% after *deductible*	80% after *deductible*

Combined in- and *out-of-network* maximum of 60 days per *benefit period*. Services applied to the *deductible* count towards this day maximum.

Other Services	80% after *deductible*	80% after *deductible*

Includes *ambulance, durable medical equipment, hospice* services, *medical supplies,* orthotic devices, private duty nursing, *prosthetic appliances,* and *home health* care. Orthotic devices for correction of *positional plagiocephaly* are limited to a *lifetime maximum* of $600.

Lifetime Maximum, Deductible, and *Coinsurance Maximum*

The following *deductibles* and maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.

Lifetime Maximum	Unlimited	Unlimited

Unlimited for all services, except orthotic devices for *positional plagiocephaly, infertility* and *sexual dysfunction* and substance abuse.

Deductible

Individual, per *benefit period*	$800	$800
Family, per *benefit period*	$2,400	$2,400

Charges for the following do not apply to the *benefit period deductible:*

- *inpatient* newborn care for well baby
- mental health and substance abuse services.

Coinsurance Maximum

Individual, per *benefit period*	$2,500	$2,500
Family, per *benefit period*	$5,000	$5,000

Charges for the following do not apply to the *benefit period coinsurance maximum:*

- mental health and substance abuse services.

SUMMARY OF BENEFITS *(cont.)*

	In-network	*Out-of-network*

Penalty For Failure To Obtain *Certification*

Certain services require *prior review* and *certification* by BCBSNC in order to receive benefits. You are responsible for requesting or ensuring that your *provider* requests *prior review* by BCBSNC. **Failure to request *prior review* and receive *certification* may result in allowed charges being reduced by 50% or full denial of benefits. See "Prospective Review/*Prior Review*" in "*Utilization Management*."**

Prior review and *certification* by Magellan Behavioral Health are required for *inpatient* and *outpatient* mental health and substance abuse services, except for *emergencies*. Please see the number in "Whom Do I Call?"

Mental Health And Substance Abuse Services

Prior review and *certification* by Magellan Behavioral Health are required for *inpatient* and *outpatient* services. Please see the number in "Whom Do I Call?"

Mental Health Office Services Combined in- and *out-of-network* limit of 30 *office visits* per *benefit period*.	$50 *copayment*	$50 *copayment*
Mental Health *Inpatient/Outpatient* Services Combined in- and *out-of-network* limit of 30 days per *benefit period*.	80% after *deductible*	80% after *deductible*
Substance Abuse Office Services	$50 *copayment*	$50 *copayment*
Substance Abuse *Inpatient/Outpatient* Services	80% after *deductible*	80% after *deductible*
Substance Abuse *Benefit Period Maximum*	None	
Substance Abuse *Lifetime Maximum*	$16,000	

Prescription Drug Program Guide for Duke Energy Medical Plan

medco® manages your prescription drug benefit for Duke Energy.

Prescription Drug Program

The Duke Energy Medical Plan options include outpatient prescription drug coverage currently administered by Medco Health Solutions, Inc. ("Medco"). Medco is a national pharmacy benefit manager with participating retail pharmacies that include Wal-Mart, Rite Aid, Walgreens, CVS, and others. The prescription drug program can help you save on medically necessary prescribed medications at retail pharmacies and through **Medco By Mail**, a home delivery pharmacy service.

Through the prescription drug coverage, you can:

- Purchase up to a 30-day supply of prescription medications at a participating retail pharmacy.
- Use **Medco By Mail** for up to a 90-day supply of prescription medications.
- Use online resources at www.medco.com to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- Reach Medco Member Services representatives, 24 hours a day, 7 days a week (except Thanksgiving and Christmas when holiday schedules apply) at 1-800-987-8361. Pharmacists are also available around the clock for medication consultations.

Medical Plan and Health Care Spending Account

(Applicable only to active employees)

The prescription drug program copays do not apply to your Medical Plan deductible or coinsurance maximum, if applicable. 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 amounts and copays with before-tax dollars by filing for reimbursement from your HCSA, using your HCSA debit card, or through the HCSA automatic reimbursement feature.

Retail Prescription Drug Program Deductible for Catastrophic Coverage Option

(Applicable only to certain retirees)

If you are enrolled in the Medical Plan's Catastrophic B coverage option, each covered individual has a $200 annual individual retail prescription drug deductible for prescription purchases made at participating retail pharmacies. The $200 deductible is separate from the Medical Plan's Catastrophic B coverage option deductible. Each covered person must meet the annual deductible before the prescription drug program copays apply to retail prescription drug purchases for that person. When you make retail prescription drug purchases at a participating pharmacy that are applied toward the prescription drug annual deductible, you will pay 100% of Medco's negotiated price for the medication that you are purchasing. When you reach the point where the amount of a prescription drug purchase will allow you to meet your annual deductible, you will pay the remaining amount of the deductible and the applicable copay amount.

For example, if the amount of your prescription purchase is $90 and there is $25 remaining to meet your annual deductible, you will pay $25, which is applied to the deductible, and the applicable copay amount for the purchase of the prescription drug.

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 for each person. You may also call Medco's Member Services to determine the portion of the deductible that has been satisfied to date.

If you are enrolled in any option other than the Medical Plan's Catastrophic B option, you are not required to satisfy an annual deductible before the prescription drug program copays apply to retail prescription drug purchases.

Formulary

Your prescription drug program includes a tiered formulary. A formulary is a list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings for the member and the Medical Plan. Due to the tiered formulary, your copay amount for prescription purchases will vary depending on whether your physician prescribes a generic, preferred brand-name or non-preferred brand-name medication. By asking your physician to prescribe generic or preferred brand-name medications, you can help control rising health care costs.

To find out whether a medication is included in the tiered formulary, visit Medco online at www.Medco.com. If you are a first time visitor to the site, please take a moment to register. Please have your member ID number available. After you log in, click "Learn about formularies" in the "Prescriptions & benefits" section. Search for a specific drug to determine if it is on the formulary. A formulary guide is included in your Medco Welcome Kit and you may also call Medco Member Services and request that a formulary guide be mailed to your home. See the prescription drug program summary of benefits for more information about applicable copays for generic, preferred brand-name and non-preferred brand-name medication.

Filling Your Prescription at a Retail Pharmacy

You can fill a prescription at a retail pharmacy for up to a 30-day supply. You will simply show your Medco ID card (with the Medco group number) at the time of your purchase. After meeting any applicable deductibles, you will pay the applicable prescription drug copay.

- If you don't identify yourself to the pharmacist as a Medco participant, or if you go to a non-participating pharmacy, you will have to pay the full price when you pick up the prescription and then submit a paper claim to Medco for reimbursement. You will be reimbursed based on the Medco negotiated price for the medication, less any required deductible and copay. Retail pharmacies that participate in the Medco retail pharmacy 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 Medco 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 participating retail pharmacy and do not identify yourself as a Medco participant by presenting your Medco 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 Medco ID card and ask the pharmacist to submit the order using the original dispensing date. Please confirm that 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 copay. This process will eliminate your need to submit a paper claim to Medco for reimbursement.

Retail Refill Allowance (Mandatory Mail) After Three Retail Refills

Generally, a 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 the Medical Plan's prescription drug program, you must use **Medco By Mail** to receive prescription coverage benefits for your maintenance medication purchases. Here's how it works:

- Beginning with the 4th retail fill of a covered maintenance medication, you will pay the entire cost of that maintenance medication if you continue to purchase it at a participating retail pharmacy. However, if you use Medco's mail-order service, **Medco By Mail**, you will pay the applicable mail order copay amount for up to a 90-day supply.
- The first three times that you purchase each maintenance medication at a participating retail pharmacy, you will pay your participating retail pharmacy copay (for members enrolled in the Medical Plan's Catastrophic B coverage option, the deductible must be met before the copay will apply). After that, you will pay the entire cost of each maintenance medication unless you choose to order through **Medco By Mail**.
- You should continue to purchase your prescriptions for short-term use, such as antibiotics, at a participating retail pharmacy. You'll pay the applicable participating retail pharmacy copay for up to a 30-day supply.

The list of maintenance medications that are addressed by the Retail Refill Allowance provision is subject to change at any time. Visit **www.medco.com** and click "Price a medication" to find out whether your medication is considered a maintenance medication and whether it is affected by any plan limits, or you may call Medco directly for more information.

Using Medco By Mail

The prescription drug program includes **Medco By Mail**, a home delivery pharmacy service, which offers a greater discount on the cost of maintenance medication and a larger supply (up to a 90-day supply) per prescription. Refer to the Retail Refill Allowance section above for a description of what constitutes a maintenance medication. To use **Medco By Mail**:

1. Ask your physician to prescribe your maintenance medication for up to a 90-day supply, plus refills for up to one year, if appropriate.
2. Mail your prescription, along with an order form and the required copay, to Medco. Order forms are available online on the Duke Energy Portal and at **www.medco.com**, or you may call Medco to request a supply of order forms.
3. Once you have established your prescription through **Medco By Mail**, you can order refills online. You will need to enter your member number (from your Medco ID card), enter the prescription number for the medication you wish to refill and verify your address. A detailed summary of your order, including costs, will be available for viewing online. Similar information will be included with your prescription when it is mailed to you.
4. You may also ask your physician to call **1-888-EASYRX1 (1-888-327-9791)** for instructions on how to fax the prescription. Remember to give your physician your Member ID and Medco group numbers (as shown on your Medco ID card); both numbers will be required for your prescription order.

If your prescription is written for less than a 90-day supply, the prescription will be filled in accordance with the day supply your physician ordered, but you will pay the entire **Medco By Mail** copay. If the medication is a federal legend, maintenance medication, a Medco pharmacist will review the prescription

and notify you if the prescription is less than the maximum days' supply available at mail. The pharmacist will offer to contact your physician on your behalf to obtain a new prescription. Please note there are certain situations that may preclude the pharmacist from contacting you directly, such as if the medication is a controlled substance, a specialty drug, or a compounded prescription.

Your prescription will be delivered to your home within 14 calendar days. With a **Medco By Mail** prescription, you will receive materials explaining the purpose of the drug, correct dosages and other helpful information. **When a prescription is ordered using Medco By Mail, Medco will automatically dispense the generic equivalent if one is available and permissible by law, unless your physician has indicated that substitution is not allowed.**

Send mail order prescriptions to:
Medco Mail Order Pharmacy
PO BOX 650322, Dallas TX 75265

Accredo Health Group – Medco's Specialty Care Pharmacy

Specialty medications are typically injectable medications administered either by you or a healthcare professional, and they often require special handling.

Conditions and therapies for which specialty medications are typically used include:

- Age-related macular degeneration
- Alpha-1 proteinase deficiency
- Anemia
- Anti-infective therapy
- Asthma
- Cancer
- Cystic fibrosis
- Deep vein thrombosis
- Fabry disease
- Gaucher disease
- Growth hormone deficiency
- Hemophilia
- Hepatitis C
- Hereditary tyrosinemia
- HIV
- Hyperparathyroidism
- Immune deficiency
- Infertility
- Insulin-like growth factor therapy
- Iron chelation therapy
- Mucopolysaccharidosis
- Multiple sclerosis
- Neutropenia
- Osteoarthritis
- Osteoporosis
- Parkinson disease
- Pompe disease
- Psoriasis
- Pulmonary hypertension
- Respiratory syncytial virus
- Rheumatoid arthritis

Under your prescription drug program, some specialty medications may *not* be covered at participating retail pharmacies or through **Medco By Mail**, but instead may only be covered when ordered through ***Accredo Health Group***, Medco's specialty care pharmacy. Accredo is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling. Services include:

- Toll-free access to specially trained pharmacists 24 hours a day, 7 days a week
- Personalized counseling from our dedicated team of registered nurses and pharmacists
- Expedited, scheduled delivery of your medications at no extra charge
- Refill reminder calls

- Coordination of home care and other healthcare services
- Free supplies, such as needles and syringes, to administer your medication

To find out whether any of your specialty medications need to be ordered through Accredo, please call Medco Member Services at the toll-free number on your prescription drug ID card.

Medicare Part B Medications
(Applicable only to Medicare Part B enrollees)

If you are eligible for Medicare Part B coverage and use a participating Medicare Part B retail pharmacy, you may not have to incur out-of-pocket expenses for your Medicare Part B-eligible medications and supplies*. Medicare Part B-eligible prescriptions may be filled through the **Medco By Mail** mail-order pharmacy or at a participating Medicare Part B retail pharmacy. In either case, the pharmacy will verify coverage and file your prescription claims with Medicare, and bill you if any balance is due. For more information about Medicare Part B coverage, call Medco Member Services toll-free at 1-800-987-8361, or visit **www.Medco.com.**

**Medicare Part B coverage will begin only after you have paid your Medicare deductible.*

Some of the medications and supplies typically covered by Medicare Part B include:

- Diabetic supplies (test strips, meters)
- Medications to aid tissue acceptance from Medicare-covered organ transplants
- Certain oral medications used to treat cancer
- Certain medications used in situations where the kidneys have completely failed

If you have Medicare Part B coverage, you will be able to fill prescriptions like these in one of two ways:

- **Medicare Part B Mail-Order Pharmacy**—When using mail order for your medication or supply needs, you will initially send your prescription to **Medco By Mail.** Then, depending on the type of medication or supply requested, **Medco By Mail** will transfer your prescription information to one of two Medicare Part B participating mail-order pharmacies—**Liberty Medical** or **Accredo Health Group**, Medco's specialty care pharmacy. Both Liberty and Accredo have extensive experience with Medicare Part B and will support the dispensing and billing of your prescriptions. They will verify coverage, file your prescription claim with Medicare, and bill you for any balance due. Depending on the covered medications or supplies that you need, Liberty or Accredo will mail your Medicare Part B medications and supplies directly to you and provide instructions for obtaining refills.
- **Medicare Part B Retail Pharmacy**—When using a participating 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 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 Coordination of Benefits processing is available and coordinated by the Part B providers. The provider will submit claims on behalf of the member to Medicare for processing as primary. Once payment is received from Medicare, the Part B provider will submit a secondary claim to Medco and the claim will process under the secondary benefit, if that is offered (for example, Medicare would pay 80% of the claim as primary, and the client would pay 20% of the claim as secondary).

A word about prescriptions covered by Medicare Part B
For more details about which medications or supplies are Medicare Part B–eligible and to learn more about your Medicare coverage:

- Visit the Medicare website at **www.medicare.gov**.
- Call Medicare Customer Service at **1 800 MEDICARE** (1 800 633-4227).

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 **Medco By Mail** or at a participating retail pharmacy (using your Medco 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.

Generic Drugs

For prescription medications, the brand-name is the product name under which a drug is advertised and sold. Generic equivalent medications contain the same active ingredients and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name counterparts. Generally, generic drugs cost less than a brand-name drug. Whenever appropriate, you should ask your physician to prescribe generic drugs. Sometimes your physician may prescribe a medication as "dispense as written" when a preferred brand-name or generic equivalent drug is available. As part of your prescription drug program, the pharmacist may discuss with your physician whether an equivalent generic or preferred brand-name drug might be appropriate for you. The final decision on your medication always rests with you and your physician, even if that decision results in a higher cost to you for your prescription medication.

Covered Expenses

The following are covered expenses unless listed as an exclusion below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes (covered at a $0 copay)
- Over-the-Counter (OTC) Diabetic Supplies (lancets, insulin syringes and needles are covered at $0 copay)
- Oral, Transdermal, Intravaginal and Injectable Contraceptives
- Drugs to Treat Impotency (all dosage forms except Yohimbine) for males age 18 and over
- Yohimbine (covered without the limits that exist for other impotency products)
- Inhaler Assisting Devices
- Peak flow meters
- Synagis/Respigam
- Hemophilia Factors
- Fertility Agents (100% covered after standard copay, up to $2500 per person per lifetime, then member pays 50% of the cost of the drug)
- Zyban and Chantix (limit of 180 days of therapy per year and 360 days of therapy per lifetime)

- Substance abuse treatments
- Dental Fluoride Products
- Anti obesity Agents (covered **Medco By Mail** only)
- Products packaged as greater than a 30 days supply are covered at mail only

Coverage limits for Certain Medications

Your prescription drug program may have certain coverage limits. For example, some quantities may be limited or some prescriptions require a coverage review. Examples of drugs with limitations or requiring coverage review are Provigil, Human Growth Hormones, Impotency Products, and Proton Pump Inhibitors (Prevacid, Protonix, Aciphex, Zegerid). Refer to www.Medco.com or call member services at 1-800-987-8361 for details.

Dispensing Limits

- The amount of drug which is to be dispensed per prescription or refill (regardless of dosage form) will be in quantities prescribed up to a 30-day supply at a participating retail pharmacy and up to a 90-day supply through **Medco By Mail**
- Thalomid limited to a 28 day supply at both retail and **Medco By Mail**

Excluded Expenses

The following are excluded from coverage 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 under the Medical Plan)
- Glucowatch Products
- Anti-obesity meds at retail
- 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
- Biologicals, Immunization agents or Vaccines
- Blood or blood plasma products
- 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 any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member
- 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

Coordination of Benefits for the Prescription Drug Program

Under the prescription drug program, Medco 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 deductible and coinsurance, you may want to use your Medco ID Card, instead of your spouse/domestic partner's plan, to obtain your prescriptions.

Please Note: Medco does coordinate benefits for Medicare Part B. Please see section titled "Medicare Part B Medications" for more details.

How to File a Prescription Drug Program Claim

When you fill your prescription at a participating retail pharmacy and identify yourself as a Medco 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, if any, and the copay.

If you do not identify yourself to the pharmacist as a Medco participant, or if you do not use a participating pharmacy, you will need to file a claim for reimbursement of your prescription drug expenses through Medco. 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, the cost, the strength, quantity, and days supply of medication, the name of the medication, prescription number and NDC number. When you submit an original receipt, keep a copy for your records. Claim reimbursement is limited to Medco's discounted price less any required deductible and copay. Medco 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 prescription medication on January 15, 2009, from a non-participating pharmacy, you must file your claim by April 15, 2010, to receive reimbursement for your expenses. Duke Energy offers new Medco prescription participants a 45-day grace period for prescription drug claims purchased at full cost in situations where the prescription ID card was not used. The grace period allows members to be reimbursed at 100%, less the applicable deductible and copay, for paper claims submitted within 45 days from a participant's initial eligibility effective date with Medco. For example, a participant who's initial effective date with Medco is January 1, 2009 would have 45 days (until February 14, 2009) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether the pharmacy was a participating or non-participating.

To obtain a claim form, call Medco Member Services at 1-800-987-8361, or go online to **www.medco.com**.

Submit claim forms to:
Medco Health Solutions, Inc.
PO Box 14711
Lexington, KY 40512

Reviews & Appeals

Medco will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Medco's control, it will notify you or your representative within 15 days after receiving the request. The extension notice will include 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 Medco 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 45 days to respond to the request for information.

Notice of Adverse Determination

In the event of an adverse benefit determination, in whole or in part, you (or your authorized representative) 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 plan benefit. An adverse benefit determination notification for any prescription drug plan claim will contain:

- 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 review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; and
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim.

When You Have a Complaint or an Appeal

If your claim is denied, you may request a full review by Medco within 180 days of the date of the adverse benefit determination. Your written letter of appeal should include the following:

- your name and member 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 Medco 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 Medco in reviewing your claim. You may request reasonable access to copies of all documents, records, and other information relevant to your claim. Medco 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. Your appeal should be mailed to:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving TX 75063
1-800-987-8361

Medco will notify you of its decision on your appeal within 15 days of its receipt of your 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:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and the claimant's right to bring an action under ERISA section 502(a);
- upon request and free of charge, reasonable access will be provided to copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal.

Second Level Appeal Process

If your claim is denied on appeal, you have a right to bring a second 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. Medco 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.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or Duke Energy 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.

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 Appeals Procedure. You may not initiate a legal action until you have completed the first and second level 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

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 Medco's 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 Medco at the address listed above.
Call Medco Member services for additional information regarding the appeals process.

This is a guide of covered expenses and expenses not covered under the prescription drug program. For more information about applicable deductibles, copays and plan limits, please call Medco Member Services or visit www.Medco.com. For more detailed information on the Medical Plan, refer to the Duke Energy Medical Plan General Information Booklet and BCBSNC Benefits Booklet sections of this Summary Plan Description. The official plan documents govern plan provisions and payment of plan benefits.

medco®

SUMMARY OF PRESCRIPTION DRUG BENEFITS

Annual Deductible (per person*) – *applies to retail pharmacy purchases*	$0	
Prescription Drug Co-pays		
You must show your Medco ID card	**Retail Pharmacy (up to a 30-day supply)**	**Mail Order (up to a 90-day supply)**
Generic	$20	$50
Preferred Brand	$40	$100
Non-Preferred Brand	$60	$150

*There is no annual family prescription drug deductible.

Medical Plan Benefits

Enhanced Exclusive Provider Organization (EPO) option

Duke Energy®

01/2009

Inside you will find:

- SECTION I: Duke Energy Medical Plan—General Information
- SECTION II: BCBSNC Benefit Booklet (includes Summary of Medical Benefits)
- SECTION III: Medco Prescription Drug Guide
- SECTION IV: Summary of Prescription Drug Benefits

The Duke Energy Medical Plan
General Information

IMPORTANT NOTICE

This General Information booklet for The Duke Energy 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 election 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 2009 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

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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, pharmacy, wellness and disease management benefits.

Based on your location and employee or retiree group, there are various Medical Plan coverage options available, such as exclusive provider organization (EPO), preferred provider organization (PPO) and high-deductible health plan (HDHP) options. If you do not have adequate access to network providers, you may qualify for out-of-area (OOA) options that mirror the PPO options. All of the Medical Plan options are designed to help you pay for health care expenses.

myHR Service Center

If you have any questions about the Medical Plan or the information in this General Information booklet, contact the myHR Service Center at 1-888-465-1300. Representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time. Information is also available through the Your Benefits Resources™ (YBR) Web site 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 (collectively referred to with Duke Energy as the "Company") 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.

International Assignment

When you are assigned by your Company to work outside the U.S. for a period that is initially expected to last at least nine consecutive months, you will cease to be eligible for the Medical Plan options available to employees on U.S. domestic assignment.

Instead, you will be eligible for the Medical Plan's special international assignment coverages. These coverages are described in a special booklet and not in the Medical Plan's General Information booklet or the other Medical Plan booklets.

Eligible Retirees

If your employment terminates on or after January 1, 2009, to be eligible for retiree coverage under the Medical Plan, at termination of employment you must:

- be employed by a Company that offers access to retiree coverage under the Medical Plan; and
- be at least age 50 and credited with at least 5 years of retiree eligibility service.

Contact the myHR Service Center if you want to know if a particular Company offers access to retiree coverage under the Medical Plan.

If your Company employment terminated before January 1, 2009, 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 for your eligible spouse and/or child(ren). If you are a Legacy Duke employee[†] who retires on or after January 1, 2006, you may be eligible to elect coverage for your eligible domestic partner. If you are a Legacy Duke employee who retired before January 1, 2006, or if you are a Legacy Cinergy retiree[‡], you are not eligible to elect coverage for your domestic partner. Please refer to the sections *Enrolling in the Medical Plan – Eligible Retirees* and *Mid-Year Coverage Changes* for additional information.

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)[•]

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."

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, which may include "common law marriage," and the spouse must meet the federal tax requirement of being a person of the opposite sex who is the taxpayer's husband or wife.

[†] When used in this booklet, the term "Legacy Duke" refers to an individual who (1) terminated employment with Duke Energy Corporation, a North Carolina corporation, and its affiliates prior to the merger of Cinergy Corp. and Duke Energy Corporation, a North Carolina corporation, (2) was employed by Duke Energy Corporation, a North Carolina corporation, and its affiliates immediately prior to such merger or (3) except as provided in footnote 2 below, was hired following such merger by a payroll company that was affiliated with (or has been designated as having been affiliated with) Duke Energy Corporation, a North Carolina corporation, immediately prior to such merger.

[‡] When used in this booklet, the term "Legacy Cinergy" refers to an individual who (1) terminated employment with Cinergy Corp. and its affiliates prior to the merger of Cinergy Corp. and Duke Energy Corporation, a North Carolina corporation, (2) was employed by Cinergy Corp. and its affiliates immediately prior to such merger, (3) was hired following such merger by a payroll company that was affiliated with (or has been designated as having been affiliated with) Cinergy Corp. immediately prior to such merger or (4) was hired by Duke Energy Business Services, LLC on or after July 1, 2008 at a work location such that he or she would have been employed by Duke Energy Shared Services, Inc. if he or she was hired to work at such location immediately prior to July 1, 2008 and he or she is so designated as Legacy Cinergy in accordance with rules prescribed by the Plan Administrator.

[§] See *Eligible Retirees* for information regarding eligible retirees' ability to elect coverage for a domestic partner.

[•] A child of divorced parents will generally be recognized by Section 152(e) of the Internal Revenue Code as a dependent of both parents for purposes of coverage under the Medical Plan.

By enrolling a spouse, you represent that the individual meets these requirements. You must immediately drop coverage for a spouse who no longer meets these requirements.

Domestic Partner Eligibility

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

- be in an ongoing, exclusive and committed relationship with one another of mutual caring and support, in which each is responsible for the other's welfare and which is intended to continue indefinitely;
- be at least 18 years old and mentally competent to enter into a legal contract;
- reside together in a joint household for the preceding 6 consecutive months;
- share financial obligations of, and be jointly responsible for, the joint household;
- not be legally married to or legally separated from anyone else, and not be in a domestic partnership with anyone else; and
- not be blood relatives to a degree where marriage would be prohibited.

Child Eligibility

Your child is:

- your biological child; **or**
- your legally adopted child, including a child placed in your home for adoption by you as long as the child remains in your home and the adoption procedure has not been terminated (a legally adopted child will not qualify as a dependent if the child has reached age 18 as of the date of adoption or placement for adoption); **or**
- a stepchild for whom you or your spouse has full or joint custody or managing conservatorship; **or**
- any other child related to you by blood or marriage or for whom you or your spouse has court-appointed legal guardianship or managing conservatorship, who is living in your household on a substantially full-time basis, who you claim as a dependent for federal income tax purposes, and with whom you have a regular parent/child relationship.

In addition to meeting the above requirements, a child must also meet the following eligibility criteria:

- Unmarried; **and**
- Primarily dependent on you for support; **and**
- Less than age 19 if not a full-time student; **or**

** See *Eligible Retirees* for information regarding eligible retirees' ability to elect coverage for a domestic partner.

- Less than age 25 if a full-time student at an accredited educational institution taking nine or more hours per term; **or**
- Any age if he or she became physically or mentally incapable of self-support while enrolled in the Medical Plan and before reaching the applicable limiting age of 19 or 25 and continuously remains incapacitated and enrolled in the Medical Plan; **or**
- Any age if he or she was physically or mentally incapable of self-support on your date of employment with the Company, was enrolled in the Medical Plan as of your employment date and continuously remains incapacitated and enrolled in the Medical Plan.

In addition, your child must meet the Internal Revenue Code requirements for tax-free health coverage to be eligible for coverage in the Medical Plan.

By enrolling a dependent child, you represent that the individual satisfies these requirements. You must immediately drop coverage for a dependent child who no longer meets these requirements.

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

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

You may be required to provide evidence of dependent eligibility, such as, but not limited to, a marriage license, divorce decree, birth certificate, court order, adoption papers, certificate/affidavit of common-law marriage or proof of joint residency. Verification of a dependent child's full-time student status may be requested at age 19 and each year beyond age 19.

To continue coverage beyond age 19 for a child who is physically or mentally incapable of self-support, you must provide evidence of your child's incapacity to the applicable Claims Administrator. The application can be obtained by contacting the 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 graduates from college), the individual(s) who become(s) ineligible for coverage will be dropped from your coverage.

You must immediately report that any dependents 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 myHR Service Center that your dependent is no longer eligible.

If you do not inform the 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 elections (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 elections);

- 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, go to the myHR link on the Duke Energy Portal or contact the 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 – Eligible Employees

When You Are First Eligible

When you are eligible to enroll as an employee, you will make your Medical Plan elections 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 elections, contact the 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.

You may also decline coverage altogether.

During Annual Enrollment

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

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, 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).

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 election change occurs (see *Mid-Year Coverage 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 life event for which you can make a change in your Medical Plan elections (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.

Enrolling in the Medical Plan – Eligible Retirees

When You Are First Eligible

If you are an eligible retiree as described in *Eligible Retirees*, 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[††];
- Individual + Child(ren); or
- Individual + Family (spouse and child(ren))

You must make your election within 31 calendar days of becoming eligible for retiree coverage.

When you are eligible to enroll as a retiree, you can make your Medical Plan elections using an online enrollment tool. You will receive additional information about the online enrollment tool when you become eligible. You can also make your Medical Plan elections by contacting the myHR Service Center.

If you have any questions or need assistance in making your enrollment elections, contact the myHR Service Center.

[††] See *Eligible Retirees* for information regarding your ability to elect coverage for a domestic partner.

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 election 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 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 election changes are allowed.

Please refer to *During Annual Enrollment* and *Mid-Year Coverage Changes* for additional information.

During Annual Enrollment

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

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. When your employment terminates, you may reelect retiree coverage; however, unless you were represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA, you will not receive additional service credit for the time you worked as an active employee after your rehire date for purposes of determining your eligibility for or the amount of any Company contribution towards the cost of retiree medical coverage, either in the form of subsidized monthly coverage under the Medical Plan or Health Reimbursement Account benefits.

Cost of Coverage

Active Employees

If you are an active employee, 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 Web site.

Paying for Coverage as an Active Employee

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 a domestic partner under the Medical Plan is deducted on a pre-tax basis. On pay advice statements, the contribution amount for your coverage will appear as a pre-tax deduction and the contribution amount for your domestic partner will appear as imputed income.

While the Company subsidy amount for domestic partner coverage under the Medical Plan is the same as for spousal coverage, the subsidy amount for domestic partner coverage is reported each pay period as imputed income to the employee and is subject to applicable taxes.

Non-tobacco user discounts may be available for certain active employee Medical Plan coverage options. To qualify for applicable non-tobacco user discounts, you and all covered dependents must not have used tobacco products, including smokeless tobacco, during the 12 months prior to the effective date of your coverage. When you enroll, you will be asked to indicate if the non-tobacco user discount applies.

Non-Tobacco User Discount – Alternate Procedure for Active Employees in Certain Medical Plan Options

If you (or your covered dependent) are unable, due to a medical condition, to meet the requirements for the non-tobacco user discount (or if it is medically inadvisable for you to attempt to meet the requirements for the non-tobacco user discount), you may still apply to receive the discount by providing these two items:

1. A written statement from your (or your covered dependent's) physician stating that you (or your covered dependent) have a medical condition that makes it unreasonably difficult (or medically inadvisable) for you (or your covered dependent) to meet the requirements for the non-tobacco user discount. This statement should identify the health factor, explaining why the health factor makes it unreasonably difficult (or medically inadvisable) for you (or your covered dependent) to meet the requirements for the discount, and recommending a specific tobacco-cessation program that is appropriate for you (or your covered dependent), and
2. Either of the following:
   - A written statement from the recommended tobacco-cessation program stating that you (or your covered dependent) are either currently enrolled or that you (or your covered dependent) have completed the program within the last 12 months, or
   - If it is your initial year of claiming the discount in accordance with this procedure, a written certification from you that you (or your covered dependent) will enroll in the tobacco-cessation program recommended by your (or your dependent's) physician within the next three months.

In order to continue the non-tobacco user discount under this procedure, a new physician's statement and a new tobacco cessation program's statement will be required each year. In order

for you to qualify for the non-tobacco user discount, you and each of your covered dependents will have to meet the requirements for the discount or satisfy the alternate procedure.

If you would like to apply for the non-tobacco user discount under the alternate procedure, you should indicate at enrollment that you are a tobacco user and then contact the myHR Service Center to discuss remitting the information required under the alternate procedure. All information must be received within 31 calendar days of the date you become an eligible employee or, in the case of enrollment during a future annual enrollment period, by the deadline communicated in your annual enrollment materials. You will pay tobacco user rates until your alternate procedure application has been approved, at which time the non-tobacco user discount will be applied on a prospective basis as soon as administratively practicable.

Retirees

If you are an eligible retiree, the cost of your retiree coverage under the Medical Plan is based on the Medical Plan coverage option that you elect and the eligible dependent(s) you choose to cover. The portion of that cost that you must pay depends on multiple factors, including your date of hire, your date of termination and your retiree group. As described below, you may be eligible for a Company contribution towards the cost of retiree medical coverage, either in the form of subsidized monthly coverage under the Medical Plan or Health Reimbursement Account benefits. Information about contribution amounts is available through the YBR Web site.

If you were hired before January 1, 2009, you may be eligible for a Company contribution towards the cost of retiree medical coverage if you terminate employment after satisfying all applicable requirements. Your eligibility for Company contributions is governed by the eligibility rules in effect at the time of your date of 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 hired on or after January 1, 2009 (including most rehired employees) and you subsequently terminate your employment with the Company as an eligible retiree, you will not be eligible for a Company contribution toward the cost of retiree medical coverage and will be responsible for paying the full cost of any retiree coverage you elect under the Medical Plan, unless you are represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA, in which case the rules directly above for individuals hired before January 1, 2009 continue to apply to you.

If you are rehired on or after January 1, 2009 and you subsequently terminate your employment with the Company as an eligible retiree, you will be eligible for a Company contribution towards the cost of retiree medical coverage only if you satisfied the eligibility requirements for Company contributions toward the cost of retiree medical coverage in effect at the time of your previous 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. The rules described in this paragraph do not apply to individuals represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA. If you are represented by one of these unions, the rules directly above for individuals hired before January 1, 2009 continue to apply to you.

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.
- You also have the option to pay contributions in advance for the quarter (three months); semi-annually or for the entire year. If you later drop coverage for any reason, your unused contributions will be refunded. Contact the myHR Service Center to set up alternate billing arrangements.
- 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 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 myHR Service Center.

If you would like to change your payment method, contact the myHR Service Center.

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 are two months behind but have been sending in partial payments, or
- you call the 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.

Reinstatement after non-payment is possible if you contact the 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.

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 elections as a newly eligible employee or retiree, coverage begins on the date you become eligible (assuming that you make your elections within 31 calendar days of becoming eligible). Deductions for your contributions (or payment for your

coverage, in the case of eligible retirees) begin as soon as administratively practicable following the date that you make your elections.

Mid-Year Coverage Changes

As a covered active employee or retiree, 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 that 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 myHR link located on the Duke Energy Portal or by contacting the myHR Service Center.

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

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 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 myHR Service Center within 31 calendar days of a loss of eligibility.

If you are eligible to make changes, the elections 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 marries or turns 19 and is not a full-time student)

- a QMCSO is received*
- your child dies

- You begin or end an international assignment scheduled for at least nine months
- 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
- You or your dependent's COBRA coverage from another employer expires
- You or your dependent becomes entitled to or loses Medicare or Medicaid*
- 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

When Mid-Year Election and Contribution Changes Are Effective

The following chart shows when coverage and contributions change if you notify the myHR Service Center of a work/life event within 31 calendar days of the event.

Election Change	Coverage	Contributions
Start or increase coverage	Coverage changes on the day the work/life event occurred (Event Date)	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*
Decrease or stop coverage (your elective decrease or coverage termination)**	Coverage changes on the first day of the month after your Election Date*	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*
Decrease coverage due to a covered individual becoming ineligible for coverage (for example, divorce, child is age 19 and not a full-time student)***	Coverage for individuals no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage (Event Date)	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*

* Court Orders. 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 may also make an election change to cancel medical coverage for the child if the order requires the child's other parent to provide coverage.

* 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.

Election Change	Coverage	Contributions
* Your Election Date is the date you submit your election changes. **Does not include termination of employment. *** Does not include death. If you die, coverage ends on the date of your death.		

Situations Impacting Your 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 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 Insurance Plan or pay under the Sick Time Pay Benefit, you may be eligible for continued coverage under the Medical Plan. Contact the 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, your Medical Plan coverage will continue as long as you remain an eligible employee and pay any required contributions, and your coverage will be primary to Medicare.

If You Become Entitled to Medicare

If you are not actively at work and you become entitled to Medicare, you will be required to enroll in an option that coordinates with Medicare. Contact the 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 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 or as an eligible retiree;
- the last day of the month in which you cease to be an eligible employee, 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 the Company informs the Claims Administrator that you (while you are still eligible) are canceling Medical Plan coverage; or
- when 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. Medical Plan coverage will actually terminate, but will be reinstated retroactive to the coverage termination date if your 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.

When your coverage ends, you will receive a certificate of coverage that indicates the length of time you had coverage under the Medical Plan to the extent required by applicable law. You may need this certificate of coverage when enrolling in another plan. With this certificate, the time you were covered may be credited toward any pre-existing condition limitations in your new plan, provided you are enrolled in the new plan within 63 days of losing your Medical Plan coverage.

Benefits if You Die

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 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 myHR Service Center.

This provision applies even if your spouse 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 that any dependents 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 when your spouse/domestic partner either does or does not report a dependent's loss of eligibility within 31 calendar days of the loss of eligibility. To drop coverage for ineligible dependents, your spouse/domestic partner should go to the YBR Web site or contact the myHR Service Center.

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.

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, go to the myHR link on the Duke Energy Portal or contact the myHR Service Center.

If You Leave the Company

If your employment with the Company terminates, your coverage under the Medical Plan will end, unless you elect to continue coverage under COBRA or as an eligible retiree.

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

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 COBRA continuation coverage under the terms of COBRA, to maintain consistent administration, Duke Energy will apply the same rules to a domestic partner as to a spouse.

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,
- entitlement to Medicare, 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*.)

Bankruptcy Proceeding

If you are a retired employee and you or your eligible dependents lose coverage resulting from a bankruptcy proceeding against your Company, you may qualify for continuation coverage under COBRA.

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. The disability must last at least until the end of the 18-month period of continuation coverage.

You must notify the myHR Service Center in writing within the initial 18-month coverage period and within 60 days of the Social Security Administration's determination. Your verbal notice is not binding until confirmed in writing and the myHR Service Center receives a copy of the Social Security disability determination. You must also notify the 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, 2009, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2010, 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, 2012; or
- 18 months following your termination of employment - July 1, 2011

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2012 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 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 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;
- you become entitled to Medicare;
- you or an eligible dependent is determined to be disabled by the Social Security Administration

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

Duke Energy'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 will also 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 used 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 will also affect continued coverage under COBRA. You will be notified prior to 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. (If the other plan limits coverage of a pre-existing condition, COBRA coverage may be continued in certain circumstances).

Pre-existing Condition Limitation

If you become covered under another group medical plan and are affected by a pre-existing condition limitation under that plan, COBRA coverage may continue for that condition until you have satisfied the pre-existing condition limitation, as long as you remain within the COBRA period. When you are eligible for full benefits under your new plan, your COBRA coverage will be terminated.

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.

Medical Child Support Orders

If the Company receives notification that, as a result of a Qualified Medical Child Support Order, 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 may also sign claim forms and assign benefits to providers. The Claims Administrator will send notification of payment to 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 these guidelines:

- 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.
- 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
526 South Church Street
Charlotte, NC 28202
704-594-6200
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 plan number assigned to the Medical Plan is 502.

Funding

Benefits under the Medical Plan generally are provided from funds held by trustees. All Medical Plan claims except for post-retirement coverage for non-key employees are paid from the Duke Energy Corporation Welfare Benefits Trust VEBA I with Mellon Bank NA as trustee. Claims for post-retirement coverage for non-key employees are paid from the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II with Mellon Bank, NA as trustee. The address for Mellon Bank, NA is:

Mellon Bank, NA
One Mellon Bank Center
Pittsburgh, PA 15258

The Company may also provide benefits under the Medical Plan through insurance or from its general assets, and may also transfer assets from the 401(h) retiree account under the Duke Energy Corporation Master Retirement Trust to the Medical Plan to provide benefits for post-retirement coverage for non-key employees.

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy 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 the Claims Committee, which serves 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 and the Claims Committee may be contacted as follows:

Benefits Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285
704-594-6200

Claims Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285
704-594-6200

The Benefits Committee has appointed the Claims Administrators, which 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 can also obtain additional information by contacting the myHR Service Center.

The Benefits Committee, the Claims Committee and the Claims Administrators, 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 and the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II is the Duke Energy Investment Committee. The Chief Executive Officer of Duke Energy Corporation, or its delegate, appoints the Chairman of the Investment Committee, who in turn appoints the other members of the Investment Committee.

The Investment Committee oversees the maintenance and investment of plan assets for which it is named fiduciary, selects investment managers and collective investment funds, issues investment guidelines and objectives and monitors investment performance. The Investment Committee may be contacted through the following address:

Investment Committee
General Manager, Long Term Investments
Duke Energy Corporation
526 South Church Street, EC04Z
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:

Vice President, Legal
139 East Fourth Street - Room 25 ATII
P.O. Box 960
Cincinnati, OH 45201-0960
(513) 419-1851

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

Affiliated Employers of the Company That Have Adopted the Medical Plan

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

Claim Determination Procedures Under ERISA

The following are two different types of claims that may be made under the Medical Plan:

- claims for Medical Plan benefits; and
- 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 Medical Plan option (referred to as an "Eligibility or Enrollment Claim").

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 can also obtain additional information by calling the 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

Authority to decide an Eligibility or Enrollment Claim is assigned for initial claims to Duke Energy Human Resources, which is the Initial Claim Administrator. Human Resources has delegated its authority to the Hewitt Associates Benefits Determination Review Team. For denied claims on review, authority is assigned to the Duke Energy Claims Committee, which is the Denied Claim Reviewer.

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 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 the Benefit Determination Review Team within 90 days after the end of the plan year in which you are claiming eligibility/enrollment should have occurred.

The Benefits Determination Review Team 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 the Benefit Determination Review Team's control, it will notify you or your representative within 30 days after receiving the request. The extension notice will include 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 the Benefits Determination Review Team 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 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;
- 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 Medical Plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse determination on appeal;
- 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; and
- if the adverse determination is based on a medical necessity or experimental or investigative treatment, either a clinical or scientific explanation of the determination, applying the terms of the Medical Plan to your medical circumstances, or a statement that such clinical or scientific explanation will be provided free of charge upon request.

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.

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

Claims Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285

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. Someone other than an individual involved in the initial determination, or a subordinate of such individual, will make the determination on appeal.

You will be notified regarding the decision on your claim within 60 days. The determination of your appeal will be in writing and, if adverse, will contain the following:

- the specific reasons for the adverse determination of your appeal;
- 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 statement regarding your right to sue under Section 502(a) of ERISA following an adverse determination on your appeal 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 or investigative treatment, either a clinical or scientific explanation of the determination, applying the terms of the Medical Plan to your medical circumstances, or a statement that such clinical or scientific explanation will be provided free of charge upon request; and
- the 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."

After completing all mandatory appeal levels, you have the right to further appeal adverse determinations by bringing a civil action under ERISA. Please refer to the *Statement of ERISA Rights* section below.

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 Appeals 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 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 Denied Claim Reviewers' decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or 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.

Right to Change or Terminate the Medical Plan

Duke Energy 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 is also 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, 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 the Board of Directors, 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 insurance contracts, collective bargaining agreements and 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 insurance contracts and 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 person under 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* 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 summary plan description and the documents governing the Medical Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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 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 your 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 may also 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 myHR Service Center, if applicable, if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child marries, ceases to be a full-time student or is otherwise no longer an eligible dependent, contact the myHR Service Center as soon as possible. Certain work/life events allow you to change benefit elections that you previously made, but to do so, you must make the benefit election change within 31 calendar days of the work/life event.

A Final Note

Although this SPD describes the principal features of the Medical Plan that are generally applicable, it 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 be amended only by proper corporate action and not by oral or written communications about benefits under the Medical Plan.

Neither the Medical Plan, this SPD, nor your Medical Plan participation is an employment contract, and does 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.

Benefit Booklet
For Participants of
Duke Energy Medical Plan
for

BlueOPTIONS℠

EPO
(Blue Card Network)

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET

This benefit booklet describes benefits provided under the Duke Energy Medical Plan Exclusive Provider Organization (EPO) option (the *Plan*). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. **Please read this benefit booklet carefully.**

The benefit plan described in this booklet is an employee health benefit plan, subject to the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Conditions, limitations and exclusions are set forth in this benefit booklet for easy reference.

In the event of a conflict between this benefit booklet and the terms in the *Plan* document, the *Plan* document will control.

Quick Reference - Toll Free Phone Numbers, Web Site and Addresses

BCBSNC Web Site www.bcbsnc.com/members/duke-energy	To find a network provider by location or specialty, get general benefit information, search through our corporate medical policies to see medical criteria used to administer your benefits, obtain claim forms, access information about all the Blue Extras℠ discounts, "proof of coverage" portability certificates and more.
Member Services Web Site www.bcbsnc.com/members/duke-energy	To enroll in a safe and secure customer service web site to: Check claim status, verify benefits and eligibility or request a new ID card.
BCBSNC Customer Service 1-888-554-3202 8 a.m-8 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new ID card requests.
Magellan Behavioral Health 1-800-359-2422	For mental health and substance abuse inpatient and outpatient pre-certification. Note: You do not need certification for office visits.
Blue Card® PPO Program 1-800-810-BLUE (2583)	To find a participating provider.
Medical Claims Filing: BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
Add/Remove Someone From Your Policy	Contact Duke Energy's myHR Service Center at 1-888-465-1300

Tips for Getting the Most Out of Your Health Care Benefits

1

Manage your out-of-pocket costs by managing the locations in which you receive care

Generally speaking, care received in a doctor's office is the most cost-effective for you, followed by hospital outpatient services. Hospital inpatient services often bear the highest cost. In addition, remember that in-network care (services from a BCBSNC participating provider who agrees to charge specified rates) will cost you less than similar care provided by an out-of-network provider. Know what your financial responsibility is before receiving care.

2

Pick a primary care physician

While our products do NOT require you to have a primary care physician, we strongly urge you to select and use one. A primary care physician informs you of your health care options, documents your care, and maintains your records for you. In addition, they save you time and unnecessary copayments by recommending appropriate specialists, coordinating your care with them, and informing them of things such as your medical history and potential drug interactions.

3

Understand your health care plan

The more you know about your benefits, the easier it will be to take control of your health. Let BCBSNC help you understand your plan and use it effectively through our customer-friendly Web site (**www.bcbsnc.com/members/duke-energy**), toll free Customer Service line (1-888-554-3202).

MEMBER RIGHTS AND RESPONSIBILITIES

As a Blue Cross and Blue Shield of North Carolina member, you have the right to:

- Receive, upon request, information about Blue Options including its services, doctors, a benefit booklet, benefit summary and directory of in-network providers
- Receive courteous service from BCBSNC
- Receive considerate and respectful care from your in-network providers
- Receive the reasons for BCBSNC's denial of a requested treatment or health care service, including (upon request) an explanation of the Utilization Management criteria and treatment protocol used to reach the decision
- Receive (upon request) information on the procedure and medical criteria used by BCBSNC to determine whether a procedure, treatment, facility, equipment, drug or device is investigational, experimental or requires prior approval
- Receive accurate, reader-friendly information to help you make informed decisions about your health care
- Participate actively in all decisions related to your health care
- Discuss all treatment options candidly with your health care provider regardless of cost or benefit coverage
- Expect that measures will be taken to ensure the confidentiality of your health care information
- File a grievance and expect a fair and efficient appeals process for resolving any differences you may have with BCBSNC
- Be treated with respect and recognition of your dignity and right to privacy
- Voice complaints or appeals about the organization or the care it provides
- Make recommendations regarding the organization's members' rights and responsibilities policies

As a Blue Cross and Blue Shield of North Carolina member, you have the responsibility to:

- Present your ID card each time you receive services
- Give your doctor permission to ask for medical records from other doctors you have seen. You will be asked to sign a transfer of medical records authorization form.
- Read your Blue Options benefit booklet and all other Blue Options member materials
- Call BCBSNC Customer Services if you have a question or do not understand the material provided by BCBSNC
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, tell your doctor.
- Provide complete information about any illness, accident or health care issues to BCBSNC and providers
- Make and keep appointments for non-emergency medical care. If it is necessary to cancel an appointment, give the doctor's office adequate notice.
- Participate in understanding your health problems and the medical decisions regarding your health care
- Be considerate and courteous to Blue Options providers, their staff and BCBSNC representatives
- Notify your employer and BCBSNC if you have any other group coverage
- Notify your group administrator of any changes regarding dependents and marital status
- Protect your ID card from unauthorized use.

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WELCOME TO BLUE OPTIONS

Welcome to Blue Cross and Blue Shield of North Carolina's Blue Options plan!

As a *member* of the Blue Options plan, you will enjoy quality health care from a network of health care *providers* and easy access to *in-network specialists*. There are no benefits for services from *out-of-network providers*. You may verify a North Carolina *provider's* participation by calling Customer Services at the number given in "Whom Do I Call?"

You may receive, upon request, information about Blue Options, its services and *doctors*, including this benefit booklet with a benefit summary, and a directory of *in-network providers*.

How To Use Your Blue Options Benefit Booklet

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. Please read it carefully.

If you are trying to determine whether coverage will be provided for a specific service, you may want to review all of the following:

- "Summary of Benefits" to get an overview of your specific benefits, such as *deductible*, *coinsurance* and maximum amounts
- "*Covered Services*" to get more detailed information about what is covered and what is excluded from coverage
- "*Utilization Management*" for important information about when *prior review* and *certification* are required
- "What Is Not Covered?" to see general exclusions from coverage.

If you still have questions, you can call BCBSNC Customer Services at the number listed on your *ID Card* or in "Whom Do I Call?" and get further information.

As you read this benefit booklet, keep in mind that any word you see in **italics *(italics)* is a defined term** and will appear in "Definitions" at the end of this benefit booklet.

You will also want to review the following sections of this benefit booklet:

- "How Blue Options Works" explains the coverage levels available to you
- "What If You Disagree With A Decision?" explains the rights available to you when BCBSNC makes a decision and you do not agree.

Notice For Non-English Speaking *Members*

This benefit booklet contains a summary in English of your rights and benefits under the *Plan*. If you have difficulty understanding any part of this benefit booklet, contact BCBSNC Customer Service to obtain assistance.

AVISO PARA *AFILIADOS* QUE NO HABLAN INGLES

Este manual de beneficios contiene un resumen en inglés de sus derechos y beneficios que le ofrece el *Plan*. Si usted tiene dificultad en entender alguna sección de este manual, por favor llame al BCBSNC Customer Service para recibir ayuda.

WHOM DO I CALL?

BCBSNC Web Site

To view your claims, get *Plan* information, claim forms, health and wellness information, find a *doctor,* change your address, and request new *ID cards*, visit the BCBSNC Web site: **www.bcbsnc.com/members/duke-energy**

BCBSNC Customer Service

For questions about your benefits or claims, *ID card* requests, or to voice a complaint:

BCBSNC Customer Service ..... 1-888-554-3202 (toll free)

Mental Health And Substance Abuse Services

Companies who have signed contracts with BCBSNC administer these benefits. You must contact these vendors directly and request *prior review* for *inpatient* and *outpatient* services, except for *office visit* services and in *emergencies.* In the case of an *emergency*, please notify the vendor as soon as reasonably possible:

Magellan Behavioral Health ..... 1-800-359-2422 (toll free)

HealthLine Blue SM

To receive confidential, up-to-date health information 24 hours a day from specially trained nurses:

HealthLine Blue ..... 1-877-477-2424 (toll free)

COBRA Administrator

UMR ..... 1-800-523-3578 (toll free)

Prior Review

Some services require *prior review* and *certification* by BCBSNC. The list of these services may change from time to time. Please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed above for current information about which services require *prior review.* See "Prospective Review/*Prior Review*" in "*Utilization Management*" for information about the review process. To request *prior review,* call:

Providers ..... 1-800-214-4844 (toll free)
Members ..... 1-877-258-3334 (toll free)

HOW BLUE OPTIONS WORKS

In-Network Benefits

In-network providers are health care professionals and facilities that have contracted with BCBSNC, or *providers* participating in the BlueCard PPO program. *In-network providers* agree to limit charges for *covered services* to the *allowed amount*. If the billed amount is greater than the *allowed amount*, you are not responsible for the difference. You pay only the applicable *copayment* or *coinsurance*, and noncovered expenses. Your *in-network provider* is required to use the Blue Options network *hospital* where he/she practices, unless that *hospital* cannot provide the services you need.

Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the Blue Options program. Your *ID card* tells participating *providers* that you are a *member* of BCBSNC. When you use a *provider* participating in the local Blue Cross or Blue Shield Plan's *provider* network, benefits are provided at the *in-network copayment* or *coinsurance*.

You are not required to obtain any referrals to see an *in-network provider*. *In-network providers* will file claims for you. It is the *member's* responsibility to request *prior review* when necessary. *Prior review* is not required for an *emergency*.

The list of *in-network providers* may change from time to time. *In-network providers* are listed on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" Please note that *dentists* and orthodontists do not participate in the *provider* network.

Out-Of-Network Benefits

There are no benefits for services from *out-of-network providers*.

Out-Of-Network Benefit Exceptions

In an *emergency*, in situations where *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, or in continuity of care situations, *out-of-network* benefits will be paid at your *in-network copayment* or *coinsurance* and will be based on the billed amount. However, you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement. If you are billed by the *provider*, you will be responsible for paying the bill and filing a claim with BCBSNC.

For more information, see "*Emergency* Care," "Continuity Of Care" in "*Utilization Management*," and for information about BCBSNC's access to care standards, see the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy**. If you believe an *in-network provider* is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an *out-of-network provider*.

The Role Of A *Primary Care Provider (PCP)* Or *Specialist*

It is important for you to maintain a relationship with a *PCP*, who will help you manage your health and help you make decisions about your health care. If you change *PCPs*, be sure to have your medical records transferred, especially immunization records, to provide your new *doctor* with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care *provider* regardless of cost or benefit coverage. *PCPs* are trained to deal with a broad range of health care issues and can help you to determine when you need a *specialist*.

Please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service to be sure the *provider* you choose is available to be a *PCP*. You may want to confirm that the *provider* is in the network before receiving care.

If your *PCP* or *specialist* leaves the BCBSNC *provider* network and they are currently treating you for an ongoing special condition, see "Continuity Of Care" in "*Utilization Management*."

Members with serious or chronic disabling or life-threatening conditions may be allowed to select the *specialist* treating this condition as their *PCP*. The selected *specialist* would be responsible for providing and coordinating the *member's* primary and specialty care. The selection of a *specialist* under these circumstances shall be made under a treatment plan approved by the *specialist*, and BCBSNC, with notice to the *PCP* if applicable. A request may be denied where it is determined that the *specialist* cannot appropriately coordinate the *member's* primary and specialty care. To make this request or if you would like the professional qualifications of your *PCP* or *in-network specialist*, you may call BCBSNC Customer Service at the number given in "Whom Do I Call?"

Carry Your *Identification Card*

Your *ID card* identifies you as a Blue Options *member*. If any information on your *ID card* is incorrect or if you need additional cards, please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC

HOW BLUE OPTIONS WORKS *(cont.)*

Customer Service at the number listed in "Whom Do I Call?" **Be sure to carry your *ID card* with you at all times and present it each time you seek health care.**

Making An Appointment

Call the *provider's* office and identify yourself as a Blue Options *member*. Please ask the receptionist whether the *provider's* office is *hospital*-owned or operated or provides *hospital*-based services. Your *medical services* may be covered under *Outpatient* Services benefit. Your *provider* directory will also help you make this determination. *Provider* directories are available through the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or by calling BCBSNC Customer Service at the number given in "Whom Do I Call?" If you need nonemergency services after your *provider's* office has closed, please call your *provider's* office for their recorded instructions. You may also contact the nurse advice line, HealthLine Blue, for assistance.

If you cannot keep an appointment, call the *provider's* office as soon as possible. Charges for missed appointments, which *providers* may require as part of their routine practice, are not covered.

HealthLine Blue

You may call a HealthLine Blue nurse to assist you with medical questions, offer support, and send you free videotapes and brochures on health topics appropriate for your condition. *Members* may ask to speak with the same nurse on an ongoing basis. You may also visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** to search a library of current health topics, send secure messages to the HealthLine Blue nurses, learn about symptoms and medications and use tools that guide you through important health care decisions. See the number listed in "Whom Do I Call?" to speak to a HealthLine Blue nurse.

How To File A Claim

In-network providers will file claims for you. When you file a claim, mail the completed claim form for all *medical services*, including mental health and substance abuse services, to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

COVERED SERVICES

Blue Options covers only those services that are *medically necessary*. Also keep in mind as you read this section:

- **Certain services require *prior review* and *certification* in order for you to avoid a partial (penalty) or complete denial of benefits. General categories of services are noted below as requiring *prior review*. Also see "Prospective Review/*Prior Review*" in "*Utilization Management*" for information about the review process, and visit the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or call BCBSNC Customer Service to ask whether a specific service requires *prior review* and *certification*.**
- Exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "*Covered Services*." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "*Covered Services*," "Summary Of Benefits" and "What Is Not Covered?"
- You may also receive, upon request, information on the procedure and medical criteria used by BCBSNC to determine whether a procedure, treatment, facility, equipment, drug or device is *medically necessary* and eligible for coverage, *investigational* or *experimental*, or requires *prior review* and *certification* by BCBSNC. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. If you need more information about BCBSNC medical policies, see the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy**, or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Office Services

Care you receive as part of an *office visit* or house call is covered with a *copayment*, except as otherwise noted in this benefit booklet. Some *providers* may receive items such as supplies or drugs from third parties. In these cases, you may be billed directly by the supplier. Benefit payments for these services will be based on the type of supplier and how the services are billed.

The *Plan* also provides benefits for six nutritional visits per *benefit period*. Your benefits cover a total of six visits to an *in-network provider*. If you see an *in-network provider*, any applicable *copayment*, or *coinsurance* is waived for these six visits.

A *copayment* will not apply if you only receive services, such as allergy shots or other injections, and are not charged for an *office visit*.

Certain diagnostic imaging procedures, such as CT scans and MRIs, are subject to *coinsurance* and any applicable *deductible*, and may require *prior review* and *certification* or services will not be covered.

Some *doctors* or *other providers* may practice in *outpatient clinics* or provide *hospital*-based services in their offices. These services are covered as *Outpatient* Services and are listed as *Outpatient Clinic* Services in "Summary Of Benefits." The *provider* search on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** indicates which *providers* will collect *deductible* and *coinsurance*, or you can call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for this information.

Office Services Exclusion

- Services in free-standing surgical facilities, independent laboratories, therapy facilities or *outpatient hospital* departments.

Preventive Care

The *Plan* covers *preventive care* services that can help you stay safe and healthy.

Routine Physical Examinations

One routine physical examination and related diagnostic services per *benefit period* will be covered for each *member* age two and older.

Well-Baby And Well-Child Care

These services are covered for each *member* up to 24 months of age including periodic assessments and immunizations. Benefits are limited to six well-baby visits for *members* through 12 months old and three well-child visits for *members* 13 months to 24 months old.

Immunizations

The full series of standard immunizations recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians (AAFP) is covered.

Covered immunizations include the following:

- Tetanus, diphtheria, pertussis (Td/Tdap)
- Polio
- HiB
- Hepatitis A and B

- Measles-Mumps-Rubella (MMR)
- Influenza
- Pneumococcal vaccine
- Shingles
- Meningococcal vaccine.
- Human papillomavirus vaccine
- Chicken pox
- Rotavirus

Immunizations Exclusions

- Immunizations required for occupational hazard
- Immunizations required for international travel.

Gynecological Exam And Cervical Cancer Screening

The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and *doctor's* interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papilloma virus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

Ovarian Cancer Screening

For female *members* age 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered. A female *member* is considered "at risk" if she:

- Has a family history with at least one first-degree relative with ovarian cancer; and a second relative, either first-degree or second-degree with breast, ovarian, or nonpolyposis colorectal cancer; or
- Tested positive for a hereditary ovarian cancer syndrome.

Screening Mammograms

Beginning at age 35, one screening mammogram will be covered per female *member* per calendar year, along with a *doctor's* interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a *doctor* when a female *member* is considered at risk for breast cancer.

A female *member* is "at risk" if she:

- Has a personal history of breast cancer
- Has a personal history of biopsy-proven benign breast disease
- Has a mother, sister, or daughter who has or has had breast cancer, or
- Has not given birth before the age of 30.

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic *member* who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer. Increased/high risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered *surgery,* such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as Hemoccult screenings.

The *provider* search on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** can help you find office-based *providers* or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for this information.

Prostate Screening

One prostate specific antigen (PSA) test or an equivalent serological test will be covered per male *member* per calendar year. Additional PSA tests will be covered if recommended by a *doctor.*

Diagnostic Services

Diagnostic procedures such as laboratory studies, radiology services and other diagnostic testing, which may include electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs), help your *doctor* find the cause and extent of your condition in order to plan for your care.

Certain diagnostic imaging procedures, such as CT scans and MRIs, may require *prior review* and *certification* or services will not be covered.

Your *doctor* may refer you to a freestanding radiology center for these procedures. Separate benefits for interpretation of diagnostic services by the attending *doctor* are not provided in addition to benefits for that *doctor's* medical or surgical services, except as otherwise determined by BCBSNC.

Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure. See "Summary Of Benefits."

Bone Mass Measurement Services

The *Plan* covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if *medically necessary*. Qualified individuals include *members* who have any one of the following conditions:

- Estrogen-deficient and at clinical risk of osteoporosis or low bone mass
- Radiographic osteopenia anywhere in the skeleton
- Receiving long-term glucocorticoid (steroid) therapy
- Primary hyperparathyroidism
- Being monitored to assess the response or effect of commonly accepted osteoporosis drug therapies
- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

See *Outpatient* Services in the "Summary Of Benefits."

Emergency Care

The *Plan* provides benefits for *emergency services*. An *emergency* is the sudden and unexpected onset of a condition of such severity 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 an individual, or with respect to a pregnant woman the health of the pregnant woman or her unborn child, in serious jeopardy
- Serious physical impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Death.

Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of *emergencies*.

What To Do In An *Emergency*

In an *emergency*, you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community emergency resources to obtain assistance in handling life-threatening *emergencies*. If you are unsure if your condition is an *emergency*, you can call HealthLine Blue; and a HealthLine Blue nurse will provide information and support that may save you an unnecessary trip to the emergency room.

Prior review is not required for *emergency services*. Your visit to the emergency room will be covered if your condition meets the definition of an *emergency*.

If you go to an emergency room for treatment of an *emergency*, your *coinsurance* will be the same, whether you use an *in-network* or *out-of-network provider*. When you receive these services from an *out-of-network provider*, benefits are based on the billed amount. However you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement, and you may be required to pay the entire bill at the time of service, and file a claim with BCBSNC.

Prior review and *certification* by BCBSNC are required for *inpatient* hospitalization and other selected services following *emergency services* (including screening and stabilization) in order to avoid a penalty. You may need to transfer to an *in-network hospital* once your condition has been *stabilized* in order to continue receiving *in-network* benefits.

Care Following *Emergency Services*

In order to receive *in-network* benefits for follow-up care related to the *emergency* (such as *office visits* or therapy once you left the emergency room or were discharged from the *hospital*), you must use *in-network providers*. Follow-up care related to the *emergency* condition is not considered an *emergency* and will be treated the same as a normal health care benefit.

Urgent Care

The *Plan* also provides benefits for *urgent care* services. When you need *urgent care*, call your *PCP*, a *specialist* or go to an *urgent care provider*. If you are not sure if your condition requires *urgent care*, you can call HealthLine Blue.

COVERED SERVICES (cont.)

Urgent care includes services provided for a condition that occurs suddenly and unexpectedly and requires prompt diagnosis or treatment such that, in the absence of immediate care, the *member* could reasonably be expected to suffer chronic illness, prolonged impairment or the need for more serious treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female *members*. A *copayment* may apply for the *office visit* to diagnose pregnancy. If a *member* changes *providers* during pregnancy, terminates coverage during pregnancy, or the pregnancy does not result in delivery, one or more *copayments* may be charged for pre-natal services depending upon how the services are billed by the *provider*.

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 *doctor*, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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*.

If the mother chooses a shorter stay, coverage is available for a *home health* visit for post-delivery follow-up care if received within 72 hours of discharge. In order to avoid a penalty, *prior review* and *certification* are required for *inpatient* stays extending beyond 48 hours following a vaginal delivery or 96 hours following a cesarean section. For information on *certification*, contact BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Termination of Pregnancy (Therapeutic Abortion)

Benefits for therapeutic abortion are available through the first 16 weeks of pregnancy for all female *members*.

Complications Of Pregnancy

Benefits for *complications of pregnancy* are available to all female *members* including dependent children. Please see "Definitions" for an explanation of *complications of pregnancy*.

Newborn Care

Inpatient newborn care of a well baby is covered under the mother's maternity benefits described above only during the first 48 hours after a vaginal delivery or 96 hours after delivery by cesarean section. This *inpatient* newborn care (well baby) requires only one admission *copayment* or *benefit period deductible* for both mother and baby. Benefits also include newborn hearing screening ordered by a *doctor* to determine the presence of permanent hearing loss.

For additional coverage of the newborn, whether *inpatient* (sick baby) or *outpatient*, the newborn must be enrolled for coverage as a dependent child within 31 days of the birth. At this time, the baby must meet the individual *benefit period deductible* if applicable, and *prior review* and *certification* are required to avoid a penalty.

Infertility And *Sexual Dysfunction* Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of *infertility* and *sexual dysfunction* for all *members* except dependent children.

Sterilization

This benefit is available for all *members* except dependent children. Sterilization includes female tubal ligation and male vasectomy.

COVERED SERVICES (cont.)

Family Planning Exclusions

- The collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
- Artificial means of conception, including, but not limited to, artificial insemination, in-vitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm insemination (ICSI), and gamete intrafallopian tube placement (GIFT) and associated services
- Donor eggs and sperm
- Surrogate mothers
- Care or treatment of the following:
  - termination of pregnancy
  - contraceptive devices
  - reversal of sterilization
  - *infertility* and *sexual dysfunction* for dependent children.
- Elective abortion
- Treatment for *infertility* or reduced fertility that results from a prior sterilization procedure or when *infertility* or reduced fertility is the result of a normal physiological change such as menopause.

Facility Services

- *Outpatient* services received in a *hospital*, a *hospital*-based facility or an *outpatient clinic*.
- *Inpatient hospital* services. If you are admitted before the *effective date*, benefits will not be available for services received prior to the *effective date*. *Prior review* must be requested and *certification* must be obtained in advance from BCBSNC to avoid a penalty, except for maternity deliveries and *emergencies*. See "Maternity Care" and "*Emergency* Care."
- Surgical services received in an *ambulatory surgical center*
- *Covered services* received in a *skilled nursing facility*. *Prior review* must be requested and *certification* must be obtained in advance from BCBSNC to avoid a penalty. *Skilled nursing facility* services are limited to a day maximum per *benefit period*. See "Summary Of Benefits."

Other Services

Ambulance Services

The *Plan* covers services in a ground *ambulance* traveling:

- From a *member's* home or scene of an accident or *emergency* to a *hospital*
- Between *hospitals*
- Between a *hospital* and a *skilled nursing facility*

when such a facility is the closest one that can provide *covered services* appropriate to your condition. Benefits may also be provided for *ambulance* services from a *hospital* or *skilled nursing facility* to a *member's* home when *medically necessary*.

The *Plan* covers services in an air *ambulance* traveling from the site of an *emergency* to a *hospital* when such a facility is the closest one that can provide *covered services* appropriate to your condition and ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land. Nonemergency air *ambulance* services require *prior review* and *certification* or services will not be covered.

Ambulance Service Exclusion

- No benefits are provided primarily for the convenience of travel.

Blood

The *Plan* covers the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a *member's* own blood only when it is stored and used for a previously scheduled procedure.

Blood Exclusion

- Charges for the collection or obtainment of blood or blood products from a blood donor, including the *member* in the case of autologous blood donation.

Clinical Trials

The *Plan* provides benefits for participation in clinical trials phases II, III, and IV. Coverage is provided only for *medically necessary* costs of health care services associated with the trials, and only to the extent such costs

have not been or are not funded by other resources. The *member* must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of a life-threatening medical condition with services that are medically indicated and preferable for that *member* compared to non-*investigational* alternatives. In addition, the trial must:

- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical specialists
- Be approved by centers or groups funded by the National Institutes of Health, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

Clinical Trials Exclusions

- Clinical trials phase 1
- Non-health care services, such as services provided for data collection and analysis
- *Investigational* drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

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:

- Accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- *Congenital* deformity, including cleft lip and cleft palate
- Disease due to infection or tumor, including tumors, cysts and exostosis
- Temporomandibular joint (TMJ) disease, including splinting and use of intra-oral *prosthetic appliances* to reposition the bones. Surgical benefits for TMJ disease are limited to *surgery* performed on the temporomandibular joint. If TMJ is caused by malocclusion, then benefits are provided for surgical correction of malocclusion if surgical management of the TMJ is *medically necessary*. Please have your *provider* contact BCBSNC before receiving treatment for TMJ.
- Impacted wisdom teeth.

The *Plan* provides benefits for extractions, crowns, bridges, and dentures for treatment of disease due to infection or tumor. For treatment of *congenital* deformity including cleft lip and cleft palate, benefits may be provided for dentures and orthodontic braces used to treat the condition.

When any of the conditions listed above require surgical correction, benefits for *surgery* will be subject to *medical necessity* 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*. *Prior review* and *certification* are required or services will not be covered, unless treatment is for an *emergency*.

Dental Treatment Excluded Under Your Medical Benefit

- Injury related to chewing or biting
- Preventive dental care, diagnosis or treatment of or related to the teeth or gums
- For disease due to infection or tumor:
  - Dental implants
  - Treatment for periodontal disease
  - Dental root form implants or root canals
  - Orthodontic braces
- For TMJ disease:
  - Dental implants
  - Treatment for periodontal disease

- Dental root form implants or root canals
- Crowns and bridges
- Extractions
- Dentures
- Orthodontic braces

- Replacement of crowns, bridges, dentures or in-mouth appliances, except as specifically stated as covered.

Durable Medical Equipment

Benefits are provided for *durable medical equipment* and supplies required for operation of equipment when prescribed by a *doctor*. Equipment may be purchased or rented at the discretion of the *Plan*. The *Plan* provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer *medically necessary*. Certain *durable medical equipment* requires *prior review* and *certification* or services will not be covered.

Durable Medical Equipment Exclusions

- Appliances that serve no medical purpose or that are primarily for comfort or convenience
- Repair or replacement of equipment due to abuse or desire for new equipment
- Rental or purchase of wheelchairs, hospital type beds, oxygen equipment (including oxygen), insulin pumps, Glucowatch and Autosensors, nebulizers and supplies related to the use of nebulizers and other *durable medical equipment*, subject to the following:
  - The equipment must be prescribed by a physician and needed in the treatment of an illness or injury and will be provided on a rental basis for the period of treatment. At our option, such equipment may be purchased. If the equipment is purchased, benefits will be payable for subsequent repairs necessary to restore the equipment to a serviceable condition; subsequent repairs due to abuse or misuse, as determined by BCBSNC, are not covered;
  - Benefits will be limited to the standard models, as determined by BCBSNC;
  - The *Plan* will pay benefits, if determined to be *medically necessary*, for ONE of the following: a manual wheelchair, a motorized wheelchair, or motorized scooter.

BCBSNC will pay benefits for the replacement of any *durable medical equipment* subject to the proof of change in a medical condition or that the equipment is no longer usable or repairable.

Eye Exams

The *Plan* provides coverage for one routine comprehensive eye examination per *benefit period*. Diagnosis and treatment of medical conditions of the eye, and drugs administered for purposes other than for a visual examination, are not considered to be part of a routine eye exam and are subject to the benefits, limitations and exclusions of the *Plan*.

Eye Exams Exclusion

- Fitting for contact lenses, glasses or other hardware.

Home Health Care

Home health care services, such as professional services of a *registered nurse (RN)* or *licensed practical nurse (LPN)* for visits totaling 8 hours a day, are covered by the *Plan* when the *member* is *homebound* due to illness or injury. *Home health* care requires *prior review* and *certification* or services will not be covered.

Home Health Care Exclusions

- Homemaker services, such as cooking and housekeeping
- Dietitian services or meals
- Services that are provided by a close relative or a member of your household.

Home Infusion Therapy Services

Home infusion therapy is covered for the administration of *prescription drugs* directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a *doctor*. These services must be provided under the supervision of an *RN* or *LPN*. Home infusion therapy requires *prior review* and *certification* or services will not be covered.

Hospice Services

- Your coverage provides benefits for *hospice* services for care of a terminally ill *member* with a life expectancy of six months or less. Services are covered only as part of a licensed health care program centrally coordinated through an interdisciplinary team directed by a *doctor* that provides an integrated set

of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families.

***Hospice* Services Exclusion**

- Homemaker services, such as cooking, housekeeping, food or meals.

Medical Supplies

Coverage is provided for *medical supplies* such as ostomy supplies, catheters, oxygen and diabetic pump and pump supplies (needles, syringes, teststrips are covered under the pharmacy plan). To obtain *medical supplies*/equipment, please find a *provider* on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service.

***Medical Supplies* Exclusion**

- *Medical supplies* not ordered by a *doctor* for treatment of a specific diagnosis or procedure.

Orthotic Devices

Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part, are covered if *medically necessary* and prescribed by a *provider*. Foot orthotics may be covered only when custom molded to the patient. Charges for custom built orthopedic shoes when *medically necessary* must be prescribed by a *doctor* and limited to two (2) pairs per calendar year. Orthotic devices for correction of *positional plagiocephaly*, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, are subject to a benefit limit.

Orthotic Devices Exclusions

- Pre-molded foot orthotics
- Over-the-counter supportive devices.

Private Duty Nursing

The *Plan* provides benefits for *medically necessary* private duty services of an *RN* or *LPN* when ordered by your *doctor*. *Prior review* must be requested and *certification* must be obtained or services will not be covered. These services are always subject to the *deductible* and *coinsurance*, regardless of location of service.

Private Duty Nursing Exclusion

- Services provided by a close relative or a member of your household.

Prosthetic Appliances

The *Plan* provides benefits for the purchase, fitting, adjustments, repairs, and replacement of *prosthetic appliances*. The *prosthetic appliances* must replace all or part of a body part or its function. The type of *prosthetic appliance* will be based on the functional level of the *member*. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a prescription change after cataract *surgery*. Certain *prosthetic appliances* require *prior review* and *certification* or services will not be covered.

***Prosthetic Appliances* Exclusions**

- Dental appliances except when *medically necessary* for the treatment of temporomandibular joint disease
- *Cosmetic* improvements, such as implantation of hair follicles and skin tone enhancements
- Lenses for keratoconus or any other eye procedure except as specifically covered under the *Plan*.

Surgical Benefits

Surgical benefits by a professional or facility *provider* on an *inpatient* or *outpatient* basis, including pre-operative and post-operative care and care of complications, are covered. Surgical benefits include diagnostic *surgery*, such as biopsies, sigmoidoscopies and colonoscopies, and reconstructive *surgery* performed to correct *congenital* defects that result in functional impairment of newborn, adoptive and foster children.

Certain surgical procedures, including those that are potentially *cosmetic*, require *prior review* and *certification* or services will not be covered.

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter, may not be eligible for separate reimbursement. For information about coverage of multiple surgical procedures, please refer to BCBSNC's medical policies, which are on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy**, or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Anesthesia

Your anesthesia benefit includes coverage for general, spinal block or monitored regional anesthesia ordered by the attending *doctor* and administered by or under the supervision of a *doctor* other than the attending surgeon or assistant at *surgery*. Separate benefits are not available for related services. Your coverage does not provide additional benefits for local anesthetics, which are covered as part of your surgical benefit.

Mastectomy Benefits

Under the Women's Health and Cancer Rights Act of 1998, the *Plan* provides for the following services related to mastectomy *surgery*:

- Reconstruction of the breast on which the mastectomy has been performed
- *Surgery* and reconstruction of the nondiseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive *surgery*
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Please note that the decision to discharge the patient following mastectomy *surgery* is made by the attending physician in consultation with the patient.

The benefits described above are subject to the same *deductibles, copayment* or *coinsurance* and limitations as applied to other medical and surgical benefits provided under the *Plan*.

Therapies

The *Plan* provides coverage for the following therapy services to promote the recovery of a *member* from an illness, disease or injury. A *doctor* or *other professional provider* must order these services.

Short-Term Rehabilitative Therapies

The following therapies are covered only for treatment of conditions that are expected to result in significant clinical improvement in a *member's* condition:

- Occupational therapy and/or physical therapy
- Speech therapy.

Benefits are limited to a visit maximum for occupational and/or physical therapy, speech therapy, chiropractic or any combination of these therapies. These visit limits apply in all places of service except *inpatient* (e.g., *outpatient*, office and home) regardless of the type of *provider* (chiropractors, other *doctors*, physical therapists). *Short-term rehabilitative therapy* received while an *inpatient* is not included in the *benefit period maximum*.

Other Therapies

The *Plan* covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Chemotherapy, including intravenous chemotherapy. For bone marrow or peripheral blood stem cell *transplants*, see "*Transplants*."

- Radiation therapy (including accelerated partial breast radiotherapy (breast brachytherapy). Breast brachytherapy is *investigational* but will be covered upon *prior review* and *certification*, based on meeting the American Society of Breast Surgeons (ASBS) criteria.)
- Limited treatment of autism, consisting of:

  (A) Therapy to develop interactive skills and skills necessary to perform the significant activities of daily living (eating, dressing, walking, bathing, toileting, and communicating). (The therapy must be performed by a licensed medical provider approved in advance. This therapy is not intended for schooling of an individual, even if the schooling requires a special environment. The provider must submit a treatment plan including the type of therapy to be administered, the goals, setting and periodic measures for the therapy, who will administer the therapy, and the patient's current ability to perform the desired results of the therapy. The treatment plan must be approved in advance by the Claims Administrator and updated quarterly with a report on the patient's condition, progress and future treatment plans.)

  (B) Care provided in accordance with the approved treatment plan by a non-licensed medical provider who is not a member of the patient's family, if the provider has been specifically trained to interact with the autistic patient and certified by a licensed medical provider as capable of working with the child. (This benefit is payable up to $50,000 during the lifetime of the patient, for the specific diagnosis of autism.)

  (C) Training and educational services provided by licensed medical providers (or non-licensed providers as described above) under an approved treatment plan for the parents or legal guardian of an autistic individual to teach the principles and practical applications of behavior modification (This benefit is payable up to $5,000 during the lifetime of the patient.)

Therapy Exclusions

- Cognitive therapy
- Speech therapy for stammering or stuttering.

Transplants

The *Plan* provides benefits for *transplants*, including *hospital* and professional services for covered *transplant* procedures. The *Plan* provides care management for *transplant* services and will help you find a *hospital* or Blue Quality Center for Transplants that provides the *transplant* services required. Travel and lodging expenses may be reimbursed, based on BCBSNC guidelines that are available upon request from a *transplant* coordinator.

For a list of covered transplants, call BCBSNC Customer Service at the number listed in "Whom Do I Call?" to speak with a *transplant* coordinator and request *prior review*. *Certification* must be obtained in advance from BCBSNC for all *transplant*-related services in order to assure coverage of these services.

If a *transplant* is provided from a living donor to the recipient *member* who will receive the *transplant*:

- Benefits are provided for reasonable and necessary services related to the search for a donor up to a maximum of $10,000 per *transplant*. However, other costs related to evaluation and procurement are covered up to the recipient *member's* coverage limit.
- Both the recipient and the donor are entitled to benefits of this coverage when the recipient is a *member*. Benefits provided to the donor will be charged against the recipient's coverage, if they don't have coverage for same elsewhere.

Some *transplant* services are *investigational* and not covered for some or all conditions or illnesses. Please see "Definitions" for an explanation of *investigational*.

***Transplants* Exclusions**

- The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient *member*
- The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a *member*
- *Transplants*, including high dose chemotherapy, considered *experimental* or *investigational*
- Services for or related to the transplantation of animal or artificial organs or tissues.

Mental Health And Substance Abuse Services

The *Plan* provides benefits for the treatment by a of *mental illness* and substance abuse by a *hospital*, *doctor* or *other provider*. Your coverage for *in-network inpatient* and *outpatient* services is coordinated through Magellan Behavioral Health.

Separate visit limits and benefit maximums may apply. See information on *office visit* benefit maximums below.

Office Visit Services

Prior review by Magellan Behavioral Health is not required for *office visit* services. The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- *Medically necessary* biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

The following rules apply to mental health *office visit* benefit maximums:

- Each service provided by a mental health *provider* will count as one visit
- Any mental health therapy services provided by a non-mental health *provider* during the course of an *office visit* will count as one visit.

Outpatient Services

Covered *outpatient* services when provided in a mental health or substance abuse treatment facility include:

- Each service listed in this section under *office visit* services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).

Inpatient Services

Covered *inpatient* treatment services also include:

- Each service listed in this section under *office visit* services
- Semi-private room and board
- Detoxification to treat substance abuse.

Please note benefits for *inpatient* and *outpatient medical care* are limited to one visit per day.

How To Access Mental Health And Substance Abuse Services

Prior review by Magellan Behavioral Health is not required for *office visit* services. Although *prior review* is not required for *emergency* situations, please notify Magellan Behavioral Health of your *inpatient* admission as soon as reasonably possible. When you need *inpatient* or *outpatient* treatment, call a Magellan Behavioral Health customer service representative at the number listed in "Whom Do I Call?" The Magellan Behavioral Health customer service representative will refer you to an appropriate *in-network provider* and give you information about *prior review* and *certification* requirements.

Mental Health And Substance Abuse Services Exclusions And Limitations

- Psychoanalysis
- Counseling with relatives about a patient with *mental illness*, alcoholism, drug addiction or chemical dependency
- *Inpatient* confinements that are primarily intended as a change of environment
- Mental health services received in residential treatment facilities.

WHAT IS NOT COVERED?

Exclusions for a specific type of service are stated along with the benefit description in "*Covered Services.*" Exclusions that apply to many services are listed in this section. To understand all of the exclusions that apply, read "*Covered Services,*" "Summary Of Benefits" and "What Is Not Covered?" In addition, the *Plan* does not cover services, supplies, drugs or charges for:

- Provided by *out-of-network providers,* except when approved in advance by BCBSNC or in an *emergency* or *urgent care* situation
- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under the *Plan*
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- A dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group
- Dates of service received prior to the *member's effective da*te
- A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet.

A

Acupuncture and acupressure, unless services are provided by a medical *doctor*

Administrative charges billed by a *provider*, including charges for telephone consultations, failure to keep a scheduled visit, completion of claim forms, obtaining medical records, and late payments

Costs in excess of the ***allowed amount*** for services usually provided by one *doctor*, when those services are provided by multiple *doctors* or *medical care* provided by more than one *doctor* for treatment of the same condition

C

Claims not submitted to BCBSNC within 18 months of the date the charge was *incurred*, except in the absence of legal capacity of the *member*

Contraceptives, including oral and injectable contraceptives, contraceptive devices and long-term reversible contraceptives including, but not limited to, intrauterine devices and implanted hormonal contraceptives, solely prescribed for the purpose of contraception. These services are excluded at the request of your *employer.*

Convenience items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items

Cosmetic services, which include removal of excess skin from the abdomen, arms or thighs, and *surgery* for psychological or emotional reasons, except as specifically covered by the *Plan*

Services received either before or after the **coverage period** of the *Plan*, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination

Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor.*

D

Dental services provided in a *hospital,* except as specifically covered by the *Plan*, when a hazardous condition exists at the same time, or covered oral *surgery* services are required at the same time as a result of a bodily injury. Dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by the *Plan.*

The following **drugs:**

- *Prescription drugs* except as specifically covered by the *Plan*
- Injections by a health care professional of injectable *prescription drugs* which can be self-administered, unless medical supervision is required
- Clomiphene (e.g., Clomid), menotropins (e.g., Repronex) or other drugs associated with conception by artificial means

WHAT IS NOT COVERED? *(cont.)*

- *Experimental* drugs or any drug not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to *prescription drugs* used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been approved as effective in any one of the three nationally recognized drug reference guides:
    1. The American Medical Association Drug Evaluations
    2. The American Hospital Formulary Service Drug Information
    3. The United States Pharmacopoeia Drug Information.

E

Services primarily for **educational** purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by the *Plan*

Side effects and complications of noncovered services, except for *emergency services* in the case of an ***emergency***

Services that would not be necessary if a noncovered service had not been received, except for *emergency services* in the case of an ***emergency***

The following **equipment**:

- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, pool or memberships to health clubs.

Experimental services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service, except as specifically covered by the *Plan*

F

*Routine **foot care*** that is palliative or *cosmetic*

G

Genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing

H

Hearing aids or examinations for the fitting of hearing aids except as specifically covered by the *Plan*

***Holistic** medicine* services

Hypnosis except when used for control of acute or chronic pain

I

Inpatient **admissions** primarily for the purpose of receiving diagnostic services or a physical examination. *Inpatient* admissions primarily for the purpose of receiving therapy services, except when the admission is a continuation of treatment following care at an *inpatient* facility for an illness or accident requiring therapy.

Investigational services in nature or obsolete, including any service, drugs, procedure or treatment directly related to an *investigational* treatment, except as specifically covered by the *Plan*

L

Services provided and billed by a **lactation consultant**

M

Services or supplies deemed not ***medically necessary***

O

Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a *member* or for treatment of **obesity**, except for surgical treatment of morbid obesity, or as specifically covered by the *Plan*

P

Care or services from a ***provider*** who:

- Cannot legally provide or legally charge for the services or services are outside the scope of the *provider's* license or certification

WHAT IS NOT COVERED? *(cont.)*

- Provides and bills for services from a licensed health care professional who is in training
- Is in a *member's* immediate family.

R

The following **residential care** services:

- Care in a self-care unit, apartment or similar facility operated by or connected with a *hospital*
- Domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities, except for substance abuse treatment, or any similar facility or institution.

Respite care except as specifically covered by the *Plan*

S

Services or supplies that are:

- Not performed by or upon the direction of a *doctor* or *other provider*
- Available to a *member* without charge.

Treatment or studies leading to or in connection with **sex changes or modifications** and related care

Sexual dysfunction unrelated to organic disease

Shoe lifts and shoes of any type unless part of a brace

T

The following types of **therapy**:

- Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
- *Maintenance therapy*
- Massage therapy.

Travel, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the *Plan*

V

The following **vision** services:

- Radial keratotomy and other refractive eye *surgery*, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
- Eyeglasses or contact lenses, except as specifically covered in "*Prosthetic Appliances*"
- Orthoptics, vision training, and low vision aids.

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind except for external nutrition administered exclusively via tube feeding as the sole source of nutrition. External nutrition products that are administered orally are excluded.

UTILIZATION MANAGEMENT

To make sure you have access to high quality, cost-effective health care, the *Plan* has a *utilization management* (*UM*) program. The *UM* program requires that certain health care services be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are *medically necessary*, provided in the proper setting and for a reasonable length of time. **The *Plan* will honor a *certification* to cover *medical services* or supplies under the *Plan* unless the *certification* was based on a material misrepresentation about your health condition or you were not eligible for these services under the *Plan* due to termination of coverage or nonpayment of premiums.**

Rights And Responsibilities Under The *UM* Program

Your *Member* Rights

Under the *UM* program, you have the right to:

- A *UM* decision that is timely, meeting applicable federal time frames
- The reasons for BCBSNC's denial of a requested treatment or health care service, including an explanation of the *UM* criteria and treatment protocol used to reach the decision
- Have a medical director from BCBSNC make a review of all denials of service that were based upon *medical necessity*
- Request a review of denial of benefit coverage through the *grievance* process
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf.

An authorized representative may act on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under the "*Utilization Management*" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

BCBSNC's Responsibilities

As part of all *UM* decisions, BCBSNC will:

- Provide you and your *provider* with a toll-free telephone number to call *UM* review staff when *certification* of a health care service is needed
- Limit what BCBSNC requests from you or your *provider* to information that is needed to review the service in question
- Request all information necessary to make the *UM* decision, including pertinent clinical information
- Provide you and your *provider* prompt notification of the *UM* decision consistent with the *Plan*.

In the event BCBSNC does not receive sufficient information to approve coverage for a health care service within specified time frames, BCBSNC will notify you in writing that benefit coverage has been denied. The notice will explain how you may pursue a review of the *UM* decision.

Prospective Review/*Prior Review*

The *Plan* requires that certain health care services receive *prior review* as noted in "*Covered Services*." These types of reviews are called prospective reviews. **If neither you nor your *provider* requests *prior review* and receives *certification*, this may result in a partial or complete denial of benefits. General categories of services with this requirement are noted in "*Covered Services*." You may also visit the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for a detailed list of these services. The list of services that require *prior review* may change from time to time.**

If the requested *certification* is denied, you have the right to appeal. See "What If You Disagree With A Decision?" for additional information. Certain services may not be covered *out-of-network*. See "*Covered Services*."

BCBSNC will make a decision on your request for *certification* within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated within three business days after BCBSNC receives all necessary information but no later than 15 days from the date BCBSNC received the request. If your request is incomplete, then within five days from the date BCBSNC received your request, BCBSNC will notify you and your *provider* of how to properly complete your request. BCBSNC may also take an extension of up to 15 days if additional information is needed. BCBSNC will notify you and your *provider* before the end of the initial 15-day period of the information needed and the date by which BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a decision within three business days. If BCBSNC does not approve benefit coverage of a health care service, BCBSNC will notify you and the *provider* by written or electronic confirmation.

Expedited Prospective Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. BCBSNC will notify you and your *provider* of its decision as soon as possible, taking into account the medical circumstances. BCBSNC will notify you and your *provider* of its decision within 72 hours after receiving the request. If BCBSNC needs additional information to process your expedited review, BCBSNC will notify you and your *provider* of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the time period specified for you to provide the information, whichever

UTILIZATION MANAGEMENT (cont.)

is earlier, BCBSNC will make a decision on your request within a reasonable time but no later than 48 hours. An expedited review may be requested by callingBCBSNC Customer Service at the number given in "Whom Do I Call?"

Concurrent Reviews

BCBSNC will also review health care services at the time you receive them. These types of reviews are concurrent reviews.

BCBSNC will communicate concurrent review decisions to the *hospital* or other facility within three business days after BCBSNC receives all necessary information but no later than 15 days after the request. If BCBSNC does not provide *certification* of a health care service, BCBSNC will notify you, your *hospital's* or other facility's *UM* department and your *provider*. Written confirmation of the decision will also be sent to your home by U.S. mail.

For concurrent reviews, the *Plan* will remain responsible for *covered services* you are receiving until you or your representatives have been notified of the denial of benefit coverage.

Expedited Concurrent Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. If you request an extension of treatment that BCBSNC has already approved at least 24 hours before the current approved treatment ends, BCBSNC will notify you and your *provider* of its decision as soon as possible taking into account the medical circumstances, but no later than 24 hours after receiving the request.

Retrospective Reviews

BCBSNC also reviews the coverage of health care services after you receive them (retrospective reviews). Retrospective review may include a review to determine if services received in an emergency setting qualify as an *emergency*. BCBSNC will make all retrospective review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date BCBSNC received the request. When the decision is to deny benefit coverage, BCBSNC will notify you and your *provider* in writing within five business days of the decision. All decisions will be based on *medical necessity* and whether the service received was a benefit under this *Plan*. BCBSNC may take an extension of up to 15 days if additional information is needed. Before the end of the initial 30-day period, BCBSNC will notify you of the extension, the information needed and the date by which BCBSNC expects to make a decision. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days. Services that were approved in advance by BCBSNC will not be subject to denial for *medical necessity* once the claim is received, **unless the *certification* was based on a material misrepresentation about your health condition or you were not eligible for these services under the *Plan* due to termination of coverage or nonpayment of premiums**. All other services may be subject to retrospective review and could be denied for *medical necessity* or for a benefit limitation or exclusion.

Care Management

Members with complicated and/or chronic medical needs may, solely at the option of BCBSNC, be eligible for care management services. Care management (or case management) encourages *members* with complicated or chronic medical needs, their *providers*, and the *Plan*, to work together to meet the individual's health needs and promote quality outcomes. To accomplish this, *members* enrolled in or eligible for care management programs may be contacted by BCBSNC or by a representative of BCBSNC. The *Plan* is not obligated to provide the same benefits or services to a *member* at a later date or to any other *member*. Information about these services can be obtained by contacting an *in-network PCP* or *in-network specialist* or by calling BCBSNC Customer Service.

Continuity Of Care

Continuity of care is a process that allows *members* with ongoing special conditions to continue receiving care from an *out-of-network provider*, when the *member's employer* changes plans or when their *provider* is no longer in the Blue Options network. If your *PCP* or *specialist* leaves the BCBSNC *provider* network and they are currently treating you for an ongoing special condition that meets BCBSNC continuity of care criteria, BCBSNC will notify you 30 days before the *provider's* termination, as long as BCBSNC receives timely notification from the *provider*. To be eligible for continuity of care, the *member* must be actively being seen by the *out-of-network provider* for an ongoing special condition and the *provider* must agree to abide by the *Plan's* requirements for continuity of care. An ongoing special condition means:

- in the case of an acute illness, a condition that is serious enough to require *medical care* or treatment to avoid a reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires *medical care* or treatment over a prolonged period of time;
- in the case of pregnancy, the second and third trimesters of pregnancy;
- in the case of a terminal illness, an individual has a medical prognosis that the *member's* life expectancy is six months or less.

The allowed transitional period shall extend up to 90 days, as determined by the *provider*, except in the cases of:

- scheduled *surgery*, organ transplantation, or *inpatient* care which shall extend through the date of discharge and post-discharge follow-up care or other *inpatient* care occurring within 90 days of the date of discharge; and

UTILIZATION MANAGEMENT (cont.)

- second trimester pregnancy which shall extend through the provision of 60 days of postpartum care; and
- terminal illness which shall extend through the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be paid at the *member's in-network* benefit level. Continuity of care will not be provided when the *provider's* contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal. Please call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for additional information.

Further Review Of *Utilization Management* Decisions

If you receive a *noncertification* as part of the *prior review* process, you have the right to request that the *Plan* review the decision through the *grievance* process. Refer to "What If You Disagree With A Decision?"

Delegated *Utilization Management*

For *UM* and the first level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services, Magellan Behavioral Health is responsible. Claims determinations and second level *grievance* review are provided by BCBSNC.

Evaluating New Technology

In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new medical technology, procedures and equipment. These policies allow BCBSNC to determine the best services and products to offer *members*. They also help BCBSNC keep pace with the ever-advancing medical field. Before implementing any new or revised policies, BCBSNC reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. BCBSNC then seeks additional input from *providers* who know the needs of the patients they serve.

WHAT IF YOU DISAGREE WITH A DECISION?

In addition to the *UM* program, the *Plan* offers a *grievance* procedure for *members*. *Grievances* include dissatisfaction with a claims denial or any decisions (including an appeal of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services. If you have a *grievance*, you have the right to request that BCBSNC review the decision through the *grievance* process. The *grievance* process is voluntary and may be requested by the *member* or an authorized representative acting on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps To Follow In The *Grievance* Process

For each step in this process, there are specified time frames for filing a *grievance* and for notifying you or your *provider* of the decision. The review must be requested in writing, within 180 days of a denial of benefit coverage (the initial claim denial or the first level *grievance* review decision).

Any request for review should include:

- Employee's ID number
- Employee's name
- Any other information that may be helpful for the review.
- Patient's name
- The nature of the *grievance*

To request a form to submit a request for review, visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

All correspondence related to a request for a review through BCBSNC's *grievance* process should be sent to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

In addition, members may also receive assistance with *grievances* from the Managed Care Patient Assistance Program by contacting:

Managed Care Patient Assistance Program
9001 Mail Service Center
Raleigh, NC 27699-9001
Tel: (919) 733-6272
Tel (toll free in NC): 1-866-867-6272
Email: MCPA@ncdoj.gov

Following such request for review, a review will be conducted by BCBSNC, by someone who is neither the individual who made the original claims denial that is the subject of the *grievance*, nor the subordinate of such individual. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations with respect to whether a particular treatment, drug or other item is *experimental, investigational*, or not *medically necessary* or appropriate, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

First Level Grievance Review

BCBSNC will provide you with the name, address and phone number of the *grievance* coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials. For *grievances* concerning quality of health care, an acknowledgement will be sent by BCBSNC within five business days.

Although you are not allowed to attend a first level *grievance* review, BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level *Grievance* Review

Since the *Plan* is subject to *ERISA*, the first level *grievance* review is the only level that you must complete before you can pursue your *grievance* in an action in federal court.

Otherwise, if you are dissatisfied with the first level *grievance* review decision, you have the right to a second level *grievance* review. Second level *grievances* are not allowed for benefits or services that are clearly excluded by this benefit booklet or quality of care complaints. Within ten business days after BCBSNC receives your request for a second level *grievance* review, the following information will be given to you:

- Name, address and telephone number of the *grievance* coordinator
- A statement of your rights, including the right to:

WHAT IF YOU DISAGREE WITH A DECISION? *(cont.)*

- request and receive from BCBSNC all information that applies to your case
- attend the second level *grievance* review meeting
- present your case to the review panel
- submit supporting material before and at the review meeting
- ask questions of any member of the review panel
- be assisted or represented by a person of your choosing, including a family member, an *employer* representative, or an attorney
- pursue other voluntary alternative dispute resolution options.

The second level review meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level *grievance* review request. You will receive notice of the meeting date and location at least 15 days before the meeting. You have the right to a full review of your *grievance* even if you do not attend the meeting. A written decision will be issued to you within five business days of the review meeting.

Notice Of Decision

If any claim (whether expedited or nonexpedited) shall be wholly or partially denied at either the first level *grievance* or the second level *grievance* review, a written notice shall be provided to the *member* worded in an understandable manner and shall set forth:

- The specific reason(s) for the denial
- Reference to the specific the *Plan* provisions on which the decision is based
- A statement that the *member* is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the *member's* claim for benefits
- If applicable, a statement describing any voluntary appeals procedures and the *member's* right to receive information about the procedures as well as the *member's* right to bring a civil action under Section 502(a) of *ERISA* following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request
- If the decision is based on *medical necessity* or *experimental* treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *member's* medical circumstances, or a statement that such explanation will be provided without charge upon request; and
- The following statement: "You 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."

Expedited Review

You have the right to a more rapid or expedited review of a denial of coverage if a delay: (i) would reasonably appear to seriously jeopardize your or your dependent's life, health or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling BCBSNC Customer Service at the number given in "Whom Do I Call?" An expedited review will take place in consultation with a medical *doctor*. All of the same conditions for a first level or second level *grievance* review apply to an expedited review, except that the review meeting will take place through a conference call or through written communication. BCBSNC will communicate the decision by phone to you and your *provider* as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

After requesting an expedited review, the *Plan* will remain responsible for covered health care services you are receiving until you have been notified of the review decision.

Correspondence related to a request for a review through the *Plan's grievance* process should be sent to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

Delegated Appeals

Magellan Behavioral Health is responsible for the first level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services. Please forward written *grievances* to:

Magellan Behavioral Health
Appeals Department
PO Box 1619

WHAT IF YOU DISAGREE WITH A DECISION? *(cont.)*

Alpharetta, GA 30009
Second level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services is provided by BCBSNC.

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits To Which *Members* Are Entitled

The benefits described in this benefit booklet are provided only for *members*. These benefits and the right to receive payment cannot be transferred to another person. At the option of the *Plan*, payment for services will be made to the *provider* of the services, or the *Plan* may choose to pay the *participant*.

If a *member* resides with a custodial parent or legal guardian who is not the *participant*, the *Plan* will, at its option, make payment to either the *provider* of the services or to the custodial parent or legal guardian for services provided to the *member*. If the *participant* or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the *provider*.

Benefits for *covered services* specified in the *Plan* will be provided only for services and supplies that are performed by a *provider* as specified in the *Plan* and regularly included in the *allowed amount*. BCBSNC establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under the *Plan*.

Any amounts paid by the *Plan* for noncovered services or that are in excess of the benefit provided under your Blue Options coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a *member's* future claim payment. This can result in a reduction or elimination of future claims payments. Amounts paid by the *Plan* for work-related accidents, injuries, or illnesses covered under state workers' compensation laws will be recovered upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the *member*, the employer or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

Providers are independent contractors, and they are solely responsible for injuries and damages to *members* resulting from misconduct or negligence.

BCBSNC's Disclosure Of Protected Health Information (PHI)

BCBSNC takes your privacy seriously and handles all PHI as required by state and federal laws and regulations and accreditation standards. BCBSNC has developed a privacy notice that explains the procedures. To obtain a copy of the privacy notice, visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Administrative Discretion

BCBSNC has the authority to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning coverage of services, care, treatment or supplies, and reasonableness of charges. BCBSNC medical policies are guides considered when making coverage determinations.

Provider Reimbursement

BCBSNC has contracts with certain *providers* of health care services for the provision of, and payment for, health care services provided to all *members* entitled to health care benefits. BCBSNC's payment to *providers* may be based on an amount other than the actual charges, including without limitation, an amount per confinement or episode of care, agreed upon schedule of fees, or other methodology as agreed upon by BCBSNC and the *provider*. Under certain circumstances, a contracting *provider* may receive payments from BCBSNC greater than the charges for services provided to an eligible *member*, or BCBSNC may pay less than charges for services, due to negotiated contracts. The *member* is not entitled to receive any portion of the payments made under the terms of contracts with *providers*. The *member's* liability when defined as a percent of charge shall be calculated based on the lesser of the *allowed amount* or the *provider's* actual charge for *covered services* provided to a *member*.

Services Received Outside Of North Carolina

Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the BlueCard program. Your *ID card* tells participating *providers* that you are a *member* of BCBSNC. By taking part in this program, you may receive discounts from out-of-state *providers* who participate in the BlueCard program.

When you obtain health care services through the BlueCard program outside the area in which the BCBSNC network operates, the amount you pay toward such *covered services*, such as *deductibles*, *copayments* or *coinsurance*, is usually based on the **lesser** of:

- The billed charges for your *covered services*, or
- The negotiated price that the out-of-state Blue Cross and/or Blue Shield licensee ("Host Blue") passes on to BCBSNC.

This "negotiated price" can be:

- A simple discount which reflects the actual price paid by the Host Blue
- An estimated price that factors in expected settlements, withholds, contingent payment arrangements, or other nonclaims transactions, with your health care *provider* or with a group of *providers*
- A discount from billed charges that reflects the **average** expected savings with your health care *provider* or with a group of *providers*. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

The estimated or average price may be adjusted in the future to correct for over- or under-estimation of past prices. However, the amount you pay is considered a final price.

Should any state enact a law that mandates liability calculation methods that differ from the usual BlueCard program method or requires a surcharge, your required payment for services in that state will be based upon the method required by that state's law.

Right Of Recovery Provision

Immediately upon paying or providing any benefit under the *Plan*, the *Plan* shall be subrogated to all rights of recovery a *member* has against any party potentially responsible for making any payment to a *member* due to a *member's* injuries, illness or condition, to the full extent of benefits provided or to be provided by the *Plan*.

In addition, if a *member* receives any payment from any potentially responsible party as a result of an injury, illness or condition, the *Plan* has the right to recover from, and be reimbursed by, the *member* for all amounts the *Plan* has paid and will pay as a result of that injury or illness, up to and including the full amount the *member* receives from all potentially responsible parties. The *member* agrees that if the *member* receives any payment from any potentially responsible party as a result of an injury or illness, the *member* will serve as a constructive trustee over the funds for the benefit of the *Plan*. Failure to hold such funds in trust will be deemed a breach of the *member's* fiduciary duty to the *Plan*.

Further, the *Plan* will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a *member* receives from any third party, any third party's insurer or any other source as a result of the *member's* injuries. The lien is in the amount of benefits paid by the *Plan* for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a *member* due to a *member's* injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The lien can be filed with or enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the *Plan* including, but not limited to, the *member*; the *member's* representative or agent; responsible party; responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the *Plan*.

The *member* acknowledges that the *Plan's* recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the *Plan* before any other claim for the *member's* damages. The *Plan* shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the *Plan* will result in a recovery to the *member* which is insufficient to make the *member* whole or to compensate the *member* in part or in whole for the damages sustained. It is further understood that the *Plan* will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the *Plan* is not required to participate in or pay court costs or attorney fees to any attorney hired by the *member*.

The terms of this entire right of recovery provision shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the *member* identifies the medical benefits the *Plan* provided. The *Plan* is entitled to recover from **any and all** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The *member* acknowledges that BCBSNC has been delegated authority by the *Plan Administrator* to assert and pursue the right of subrogation and/or reimbursement on behalf of the *Plan*. The *member* shall fully cooperate with BCBSNC's efforts to recover benefits paid by the *Plan*. It is the duty of the *member* to notify BCBSNC in writing of the *member's* intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the *member*. The *member* shall provide all information requested by BCBSNC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as BCBSNC may reasonably request.

The *member* shall do nothing to prejudice the *Plan's* recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by the *Plan*.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the *member* and the *Plan* agree that the *Plan Administrator* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The *member* agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as BCBSNC may elect. Upon receiving benefits under the *Plan*, the *member* hereby submits to each such jurisdiction, waiving whatever rights may correspond to the *member* by reason of the *member's* present or future domicile.

Notice Of Claim

The *Plan* will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that *covered services* have been provided to a *member*. If the *member* files the claim, written notice must be given to BCBSNC within 18 months after the *member incurs* the *covered service*, except in the absence of legal capacity of the *member*. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

Notice Of Benefit Determination

BCBSNC will provide an explanation of benefits determination to the *member* or the *member's* authorized representative within 30 days of receipt of a notice of claim if the *member* has financial liability on the claim other than a *copayment* (unless your *Plan* has chosen to provide an explanation of benefits for additional claims where the *member* does not have a financial liability other than a *copayment*). BCBSNC may take an extension of up to 15 additional days to complete the benefits determination if additional information is needed. If BCBSNC takes an extension, BCBSNC will notify the *member* or the *member's* authorized representative of the extension and of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days.

Such notice will be worded in an understandable manner and will include:

- The specific reason(s) for the denial of benefits
- Reference to the benefit booklet section on which the denial of benefits is based
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed
- A description of the review procedures and the time limits applicable to such procedures, including the *member's* right to bring a civil action under Section 502(a) of *ERISA* following a denial of benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request
- If the denial of benefits is based on *medical necessity* or *experimental* treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the health benefit plan to the *member's* medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of a denial of benefits involving *urgent care*, a description of the expedited review process available to such claims.

Upon receipt of a denial of benefits, you have the right to file a *grievance* with BCBSNC. See "What If You Disagree With A Decision?" for more information.

Limitation Of Actions

Since the *Plan* is subject to *ERISA*, you must only exhaust the first level *grievance* review process following the Notice of Claim requirement. Please see "What If You Disagree With A Decision?" for details regarding the *grievance* review process. No legal action may be taken later than three years from the date *covered services* are *incurred*. However, if you are authorized to pursue an action in federal court under *ERISA*, and you choose to pursue a second level *grievance* review, the three-year limitation is temporarily suspended until that review has been resolved.

Coordination Of Benefits (Overlapping Coverage)

If a *member* is also enrolled in another group health plan, the *Plan* may coordinate benefits with the other plan. Coordination of benefits (COB) means that if a *member* is covered by more than one insurance plan, benefits under one plan are determined before the benefits are determined under the second plan. The plan that determines benefits first is called the primary plan. The other plan is called the secondary plan. Benefits paid by the secondary plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service.

Most group health insurance plans include a COB provision. The rules used to determine which plan is primary and secondary are listed in the following chart. The "participant" is the person who is signing up for health insurance coverage.

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	Yes	
	The plan with COB is		Yes
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	Yes	
	The plan covering the person as a dependent is		Yes
The person is covered as a dependent child under both plans, including when parents are divorced or separated and share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	Yes	
	The plan of the parent whose birthday is later in the calendar year is		Yes
	Note: When the parents have the same birthday, the plan that covered the parent longer is	Yes	
The person is covered as a dependent child and parents are divorced or separated with no court decree for coverage	The custodial parent's plan is	Yes	
	The plan of the spouse of the custodial parent is		Yes
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	Yes	
	The non-custodial parent's plan is		Yes
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	Yes	
	The plan of the other parent is		Yes
	Note: If there is a court decree that requires a parent to assume financial responsibility for the child's health care coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent's health benefit plan are	Yes	
The person is covered as a laid-off or retired employee or that employee's dependent, on one of the plans	The plan that covers a person other than as a laid-off or retired employee or as that employee's dependent	Yes	
	The plan that covers a person as a laid-off or retired employee or the dependent of a laid-off or retired employee		Yes
	Note: This rule does not apply if it results in a conflict in determining order of benefits		
The person is the participant in two active group health plans and none of the rules above apply	The plan that has been in effect longer is	Yes	
	The plan that has been in effect the shorter amount of time is		Yes

NOTE: Payment by BCBSNC under the *Plan* takes into account whether or not the *provider* is a participating *provider*. If the *Plan* is the secondary plan, and the *member* uses a participating *provider*, the *Plan* will coordinate up to the *allowed amount*. The participating *provider* has agreed to accept the *allowed amount* as payment in full.

BCBSNC may request information about the other plan from the *member*. A prompt reply will help BCBSNC process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits are coordinated with other group health plans, benefits for *covered services* are still subject to program requirements, such as *prior review* and *certification* procedures.

DEFINITIONS

ALLOWED AMOUNT — the charge that BCBSNC determines is reasonable for *covered services* provided to a *member*. This may be established in accordance with an agreement between the *provider* and BCBSNC. In the case of *providers* that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the *provider's* actual charge or a reasonable charge established by BCBSNC using a methodology that is applied to comparable *providers* for similar services under a similar plan. BCBSNC's methodology is based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the *provider* may be combined into one procedure for reimbursement purposes.

AMBULANCE — transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured, includes ground and aircraft.

AMBULATORY SURGICAL CENTER — a *nonhospital facility* with an organized staff of *doctors*, which is licensed or certified in the state where located, and which:

a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an *outpatient* basis
b) Provides nursing services and treatment by or under the supervision of *doctors* whenever the patient is in the facility
c) Does not provide *inpatient* accommodations
d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a *doctor* or *other provider*.

BENEFIT PERIOD — the period of time, as stated in the "Summary Of Benefits," during which charges for *covered services* provided to a *member* must be *incurred* in order to be eligible for payment by the *Plan*. A charge shall be considered *incurred* on the date the service or supply was provided to a *member*.

BENEFIT PERIOD MAXIMUM — the maximum amount of charges for *covered services* in a *benefit period* that will be reimbursed on behalf of a *member* while covered under the *Plan*.

CERTIFICATION — the determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy BCBSNC's requirements for *medically necessary* services and supplies, appropriateness, health care setting, level of care and effectiveness.

COINSURANCE — the sharing of charges by the *Plan* and the *member* for *covered services* received by a *member*, usually stated as a percentage of the *allowed amount*.

COMPLICATIONS OF PREGNANCY — medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated prior to the full term of the pregnancy (except as otherwise stated below), including, but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. *Emergency* cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as a complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy.

CONGENITAL — existing at, and usually before, birth referring to conditions that are apparent at birth regardless of their causation.

COPAYMENT — the fixed-dollar amount that is due and payable by the *member* at the time a *covered service* is provided.

COSMETIC — to improve appearance. This does not include restoration of physiological function resulting from accidental injury, trauma or previous treatment that would be considered a *covered service*. This also does not include reconstructive *surgery* to correct *congenital* or developmental anomalies that have resulted in functional impairment.

COVERED SERVICE(S) — a service, drug, supply or equipment specified in this benefit booklet for which *members* are entitled to benefits in accordance with the terms and conditions of the *Plan*

CREDITABLE COVERAGE — accepted health insurance coverage carried prior to BCBSNC coverage can be group health insurance, self-funded plans, individual health insurance, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as creditable coverage under state or federal law. Creditable coverage does not include coverage consisting solely of excepted benefits.

CUSTODIAL CARE — care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by BCBSNC without regard to the place of service or the *provider* prescribing or providing the services.

DEDUCTIBLE — the specified dollar amount for certain *covered services* that the *member* must incur before benefits are payable for the remaining *covered services*. The deductible does not include *copayments, coinsurance,* charges in excess of the *allowed amount,* amounts exceeding any maximum and expenses for noncovered services.

DEFINITIONS *(cont.)*

DENTAL SERVICE(S) — dental care or treatment provided by a *dentist* or *other professional provider* in the *dentist's* office to a covered *member* while the policy is in effect, provided such care or treatment is recognized by BCBSNC as a generally accepted form of care or treatment according to prevailing standards of dental practice.
DENTIST — a dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide *dental services,* perform dental *surgery* or administer anesthetics for dental *surgery.* All services performed must be within the scope of license or certification to be eligible for reimbursement.
DEVELOPMENTAL DYSFUNCTION — difficulty in acquiring the activities of daily living including, but not limited to, walking, talking, feeding or dressing oneself or learning in school. Developmental therapies are those to facilitate or promote the development of skills, which the *member* has not yet attained. Examples include, but are not limited to: speech therapy to teach a *member* to talk, follow directions or learn in school; physical therapy to treat a *member* with low muscle tone or to teach a *member* to roll over, sit, walk or use other large muscle skills; occupational therapy to teach a *member* the activities of daily living, to use small muscle skills or balance or to assist with behavior or achievement in the learning setting.
DOCTOR — includes the following: a doctor of medicine, a doctor of osteopathy, licensed to practice medicine or *surgery* by the Board of Medical Examiners in the state of practice, a doctor of dentistry, a doctor of podiatry, a doctor of chiropractic, a doctor of optometry, or a doctor of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner or scope of practice. All services performed must be within the scope of license or certification to be eligible for reimbursement.
DURABLE MEDICAL EQUIPMENT — items designated by BCBSNC which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home.
EFFECTIVE DATE — the date on which coverage for a *member* begins, according to "When Coverage Begins And Ends."
EMERGENCY(IES) — the sudden or unexpected onset of a condition of such severity 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 an individual or with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock, and other severe, acute conditions are examples of emergencies.
EMERGENCY SERVICES — health care items and services furnished or required to screen for or treat an *emergency* medical condition until the condition is *stabilized,* including pre-hospital care and ancillary services routinely available in the emergency department.
EMPLOYER — Duke Energy Corporation or an affiliated company that is participating in the *Plan.*
ERISA — the Employee Retirement Income Security Act of 1974.
EXPERIMENTAL — see *Investigational.*
FACILITY SERVICES — *covered services* provided and billed by a *hospital* or *nonhospital facility.* All services performed must be within the scope of license or certification to be eligible for reimbursement.
GRIEVANCE — grievances include dissatisfaction with a claims denial or any decisions (including an appeal of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services.
HOLISTIC MEDICINE — unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any *other provider.*
HOMEBOUND — a *member* who cannot leave their home or temporary residence due to a medical condition which requires both the assistance of another person and the aid of supportive devices or the use of special transportation. A *member* is not considered homebound solely because the assistance of another person is required to leave the home.
HOME HEALTH AGENCY — a *nonhospital facility* which is primarily engaged in providing home health care services medical or therapeutic in nature, and which:
a) Provides skilled nursing and other services on a visiting basis in the *member's* home,
b) Is responsible for supervising the delivery of such services under a plan prescribed by a *doctor,*
c) Is accredited and licensed or certified in the state where located,
d) Is certified for participation in the Medicare program, and
e) Is acceptable to BCBSNC.
HOSPICE — a *nonhospital facility* that provides medically related services to persons who are terminally ill, and which:
a) Is accredited, licensed or certified in the state where located,
b) Is certified for participation in the Medicare program, and
c) Is acceptable to BCBSNC.
HOSPITAL — an accredited institution for the treatment of the sick that is licensed as a hospital by the appropriate state agency in the state where located. All services performed must be within the scope of license or certification to be eligible for reimbursement.
IDENTIFICATION CARD (ID card) — the card issued to *members* upon enrollment which provides *employer/member* identification numbers, names of the *members,* applicable *copayments* and/or *coinsurance,* and key phone numbers and addresses.

INCURRED — the date on which a *member* receives the service, drug, equipment or supply for which a charge is made.
INFERTILITY — the inability of a heterosexual couple to conceive a child after 12 months of unprotected male/female intercourse.
IN-NETWORK — designated as participating in the Blue Options network. BCBSNC's payment for in-network *covered services* is described in this benefit booklet as in-network benefits or in-network benefit levels.
IN-NETWORK PROVIDER — a *hospital, doctor*, other medical practitioner or *provider* of *medical services* and supplies that has been designated as a Blue Options *provider* by BCBSNC or a *provider* participating in the BlueCard program.
INPATIENT — pertaining to services received when a *member* is admitted to a *hospital* or *nonhospital facility* as a registered bed patient for whom a room and board charge is made.
INVESTIGATIONAL (EXPERIMENTAL) — the use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, drug, or device that BCBSNC does not recognize as standard *medical care* of the condition, disease, illness, or injury being treated. The following criteria are the basis for BCBSNC's determination that a service or supply is investigational:

a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply
c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
d) The service or supply under consideration is not as beneficial as any established alternatives
e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

If a service or supply meets one or more of the criteria, it is deemed investigational except for clinical trials as described under the *Plan*. Determinations are made solely by BCBSNC after independent review of scientific data. Opinions of experts in a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered by BCBSNC but are not determinative or conclusive.
LICENSED PRACTICAL NURSE (LPN) — a nurse who has graduated from a formal practical nursing education program and is licensed by the appropriate state authority.
LIFETIME MAXIMUM — the maximum amount of *covered services* that will be reimbursed on behalf of a *member* while covered under the *Plan*.
MAINTENANCE THERAPY — services that preserve your present level of function or condition and prevent regression of that function or condition. Maintenance begins when the goals of the treatment plan have been achieved and/or when no further progress is apparent or expected to occur.
MEDICAL CARE/SERVICES — professional services provided by a *doctor* or *other provider* for the treatment of an illness or injury.
MEDICAL SUPPLIES — health care materials that include ostomy supplies, catheters, oxygen and diabetic supplies.
MEDICALLY NECESSARY (or MEDICAL NECESSITY) — those *covered services* or supplies that are:

a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under the *Plan*, not for *experimental, investigational*, or *cosmetic* purposes,
b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms,
c) Within generally accepted standards of *medical care* in the community, and
d) Not solely for the convenience of the insured, the insured's family, or the *provider*.

For medically necessary services, BCBSNC may compare the cost-effectiveness of alternative services, settings or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.
MEMBER — an *participant* or dependent, who is currently enrolled in the *Plan* and for whom premium is paid.
MENTAL ILLNESS — mental disorders, psychiatric illnesses, mental conditions and psychiatric conditions (whether organic or non-organic, whether of biological, nonbiological, chemical or nonchemical origin and irrespective of cause, basis or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC.)
NONCERTIFICATION — a determination by BCBSNC that a service covered under the *Plan* has been reviewed and does not meet BCBSNC's requirements for *medical necessity*, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of *emergency services* and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is *experimental, investigational* or *cosmetic* is considered a noncertification. A noncertification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

DEFINITIONS *(cont.)*

NONHOSPITAL FACILITY — an institution or entity other than a *hospital* that is accredited and licensed or certified in the state where located to provide *covered services* and is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OFFICE VISIT — *medical care, surgery,* diagnostic services, *short-term rehabilitative therapy* services and *medical supplies* provided in a *provider's* office.

OTHER PROFESSIONAL PROVIDER — a person or entity other than a *doctor* who is accredited and licensed or certified in the state where located to provide *covered services* and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER PROVIDER — an institution or entity other than a *doctor* or *hospital,* which is accredited and licensed or certified in the state where located to provide *covered services* and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER THERAPY(IES) — the following services and supplies, both *inpatient* and *outpatient,* ordered by a *doctor* or *other provider* to promote recovery from an illness, disease or injury when provided by a *doctor, other provider* or professional employed by a *provider* licensed in the state of practice.

a) Cardiac rehabilitative therapy — reconditioning the cardiovascular system through exercise, education, counseling and behavioral change
b) Chemotherapy (including intravenous chemotherapy) — the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the Food and Drug Administration (FDA)
c) Dialysis treatments — the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis
d) Pulmonary therapy — programs that combine exercise, training, psychological support and education in order to improve the patient's functioning and quality of life
e) Radiation therapy — the treatment of disease by x-ray, radium, or radioactive isotopes
f) Respiratory therapy — introduction of dry or moist gases into the lungs for treatment purposes.

OUT-OF-NETWORK — not designated as participating in the Blue Options network, and not certified in advance by *BCBSNC* to be considered as *in-network.* There is no payment for out-of-network *covered services* except as described in this benefit booklet.

OUT-OF-NETWORK PROVIDER — a *provider* that has not been designated as a Blue Options *provider* by BCBSNC.

OUTPATIENT — pertaining to services received from a *hospital* or *nonhospital facility* by a *member* while not an *inpatient.*

OUTPATIENT CLINIC(S) — an accredited institution/facility associated with or owned by a *hospital.* An outpatient clinic may bill for *outpatient* visits, including professional services and ancillary services, such as diagnostic tests. These services may be subject to the *Outpatient* Services benefit. All services performed must be within the scope of the professional or facility license or certification to be eligible for reimbursement.

PARTICIPANT — a person who is eligible for coverage under the *Plan* and properly enrolled.

PLAN — Duke Energy Medical Plan's Exclusive Provider Organization (EPO) option.

PLAN ADMINISTRATOR — Duke Energy Benefits Committee.

PLAN SPONSOR — Duke Energy Corporation.

POSITIONAL PLAGIOCEPHALY — the asymmetrical shape of an infant's head due to uneven external pressures on the skull in either the prenatal or postnatal environment. This does not include asymmetry of an infant's head due to premature closure of the sutures of the skull.

PREVENTIVE CARE — *medical services* provided by or upon the direction of a *doctor* or *other provider* related to the prevention of disease.

PRIMARY CARE PROVIDER (PCP) — an *in-network provider* who has been designated by BCBSNC as a PCP.

PRIOR REVIEW — the consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of *medical necessity* of services and supplies, appropriateness, health care setting, or level of care and effectiveness. Prior review results in *certification* or *noncertification* of benefits.

PROSTHETIC APPLIANCES — fixed or removable artificial limbs or other body parts, which replace absent natural ones following permanent loss of the body part.

PROVIDER — a *hospital, nonhospital facility, doctor,* or *other provider,* accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification. All services performed must be within the scope of license or certification to be eligible for reimbursement.

REGISTERED NURSE (RN) — a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program), and is licensed by the appropriate state authority in the state of practice.

ROUTINE FOOT CARE — hygiene and preventive maintenance such as trimming of corns, calluses or nails that do not usually require the skills of a qualified *provider* of foot care services.

SEXUAL DYSFUNCTION — any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

DEFINITIONS *(cont.)*

SHORT-TERM REHABILITATIVE THERAPY — services and supplies both *inpatient* and *outpatient,* ordered by a *doctor* or *other provider* to promote the recovery of the *member* from an illness, disease or injury when provided by a *doctor, other provider* or professional employed by a *provider* licensed by the appropriate state authority in the state of practice and subject to any licensure or regulatory limitation as to location, manner or scope of practice.

a) Occupational therapy — treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role after such ability has been impaired by disease, injury or loss of a body part
b) Physical therapy — treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part
c) Speech therapy — treatment for the restoration of speech impaired by disease, *surgery,* or injury; or certain significant physical *congenital* conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

SKILLED NURSING FACILITY — a *nonhospital facility* licensed under state law that provides skilled nursing, rehabilitative and related care where professional *medical services* are administered by a registered or *licensed practical nurse.* All services performed must be within the scope of license or certification to be eligible for reimbursement.

SPECIALIST — a *doctor* who is recognized by BCBSNC as specializing in an area of medical practice.

STABILIZE — to provide *medical care* that is appropriate to prevent a material deterioration of the *member's* condition, within reasonable medical certainty.

SURGERY — the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures, such as:

a) The correction of fractures and dislocations
b) Usual and related pre-operative and post-operative care
c) Other procedures as reasonable and approved by BCBSNC.

TRANSPLANTS — the surgical transfer of a human organ or tissue taken from the body for grafting into another area of the same body or into another body; the removal and return into the same body or transfer into another body of bone marrow or peripheral blood stem cells. Grafting procedures associated with reconstructive *surgery* are not considered transplants.

URGENT CARE — services provided for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis or treatment, such that in the absence of immediate care the individual could reasonably be expected to suffer chronic illness, prolonged impairment, or require a more hazardous treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

UTILIZATION MANAGEMENT (UM) — a set of formal processes that are used to evaluate the *medical necessity,* quality of care, cost-effectiveness and appropriateness of many health care services, including procedures, treatments, medical devices, *providers* and facilities.

WAITING PERIOD — the amount of time that must pass before a *member* is eligible to be covered for benefits under the terms of the *Plan.*

BlueCross BlueShield of North Carolina

MEMBER'S AUTHORIZATION REQUEST FORM
COMMERCIAL OPERATIONS / IDC

You may give Blue Cross and Blue Shield of North Carolina (BCBSNC) written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that BCBSNC communicates with members or subscribers. *For example, we will send explanation of benefits (EOB) statements to the subscriber.***

MEMBER WHOSE INFORMATION WILL BE DISCLOSED:

MEMBER'S FIRST NAME | M.I. | MEMBER'S LAST NAME

MONTH / DAY / YEAR — MEMBER'S DATE OF BIRTH

PREFIX | 9 DIGIT IDENTIFIER — SUBSCRIBER ID NUMBER *(FROM YOUR ID CARD)* | SUFFIX

At my request, I authorize BCBSNC to disclose Protected Health Information to *(enter name of person/entity who will receive member's PHI)*:

FIRST NAME | M.I. | LAST NAME

RELATIONSHIP TO MEMBER:

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: (i) your subscriber ID number, (ii) your date of birth, and (iii) subscriber address.

I authorize BCBSNC to disclose the following PHI to the person/entity listed above. CHECK ONLY BOXES THAT APPLY:

☐ ALL Information Requested ☐ Enrollment Information ☐ Benefit Information ☐ Premium Payment Information ☐ Explanation of Benefits (EOB) Information

☐ All Claims Information ☐ All Services from a Specific Health Care Provider(s) *(List Provider's Name)*: _____

☐ Other *(Please List Specific PHI and/or Date Ranges)*: _____

If you want to authorize someone to have access to your mental health or substance abuse PHI, please call the mental health/substance abuse company's telephone number on the back of your membership card to request a separate authorization form from them.

NOTE: BCBSNC will consider the effective date of this authorization to be the date BCBSNC enters this authorization into its Commercial Operations business system, typically five (5) days following receipt.

If you would like this authorization to become effective on a date after BCBSNC enters the authorization into its system, please insert the date here: → MONTH / DAY / YEAR

I would like this authorization to expire on *(enter date)*: MONTH / DAY / YEAR **OR** ☐ **When my policy expires.**

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)

I understand that I may revoke this authorization at any time by giving BCBSNC written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will not affect any action BCBSNC took in reliance on this authorization before BCBSNC received my written notice of revocation.

I also understand that BCBSNC will not condition the provision of health plan benefits on this authorization.

I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the *Health Insurance Portability and Accountability Act* ("HIPAA") or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature: _____ **Today's Date:** MONTH / DAY / YEAR

If signed by an individual other than the member: _____
PRINT YOUR FULL NAME

Describe your authority to act for the member *(e.g., power of attorney, court order, parent of minor child, etc.)*:

_____

NOTE: Please attach the legal document naming you as the personal representative if you have not previously submitted it to us.

RETURN THIS AUTHORIZATION TO:

Commercial Operations / IDC
Blue Cross and Blue Shield of North Carolina
P.O. Box 2291 • Durham, NC 27702-2291

U2516. 1/04

An Independent Licensee of the Blue Cross and Blue Shield Association

SUMMARY OF BENEFITS

This section provides a summary of your Blue Options benefits. A more complete description of your benefits is found in "*Covered Services.*" General exclusions may also apply — please see "What Is Not Covered?" As you review the "Summary Of Benefits" chart, keep in mind:

- To receive benefits, you must receive care from a Blue Options *in-network provider.* **However, in an *emergency*, or when *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, you may also receive *in-network* benefits for care from an *out-of-network provider.* Please see "*Out-Of-Network* Benefits" and "*Emergency* Services" for additional information. Access to care standards are available on the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or by calling BCBSNC Customer Service at the number listed on your *ID card* or in "Whom Do I Call?"**
- *Copayment* amounts are fixed dollar amounts the *member* must pay for some *covered services*
- Multiple *office visits* or emergency room visits on the same day may result in multiple *copayments*
- *Coinsurance* percentages shown in this section are the portion of the *allowed amount* that the *Plan* covers
- *Coinsurance* amounts are based on the *allowed amount.*

Please note: The list of *in-network providers* may change from time to time, so please verify that the *provider* is still in the Blue Options network before receiving care. Find a *provider* on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed on your *ID Card* or in "Whom Do I Call?"

Benefit period January 1 through December 31

Benefit payments are based on where services are received and how services are billed.

	In-network
Physician Office Services	
See *Outpatient* Services for *outpatient clinic* or *hospital*-based services. *Office visits* for the evaluation and treatment of obesity are limited to a maximum of four visits per *benefit period.*	
Office Services	
Primary Care Provider	$30 *copayment*
Specialist	$40 *copayment*
Includes office *surgery,* x-rays and lab tests.	
CT Scans, MRIs, MRAs and PET Scans	100%
Preventive Care	
Primary Care Provider	$30 *copayment*
Specialist	$40 *copayment*
Includes routine physical exams, well baby, well-child care, immunizations, gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests (PSAs).	
Short-term Rehabilitative Therapies	$40 *copayment*
Chiropractic Services	$40 *copayment*
Benefit period maximums apply to home, office and *outpatient* settings. 80 visits per *benefit period* for speech therapy, physical/occupational therapy, and chiropractic services combined.	

SUMMARY OF BENEFITS *(cont.)*

	In-network
Physician Office Services (cont'd)	
Other Therapies	100%
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See *Outpatient* Services for *other therapies* provided in an *outpatient* setting.	
***Infertility* and *Sexual Dysfunction* Services**	
Primary Care Provider	$30 *copayment*
Specialist	$40 *copayment*
Routine Eye Exam	$40 *copayment*
***Urgent Care* Centers and Emergency Room**	
***Urgent Care* Centers**	$60 *copayment*
Emergency Room Visit	$85 *copayment*
If admitted to the *hospital* from the emergency room, *inpatient hospital* benefits apply to all *covered services* provided. If held for observation, *outpatient* benefits apply to all *covered services* provided. If you are sent to the emergency room from an *urgent care* center, you may be responsible for both the emergency room *copayment* and the *urgent care copayment.*	
Ambulatory Surgical Center	$50 *copayment*
***Outpatient* Services**	
Physician Services	100%
***Hospital* and *Hospital*-based Services**	100%
***Outpatient Clinic* Services**	100%
Outpatient Diagnostic Services:	
Outpatient lab tests and mammography when performed alone	100%
Outpatient lab tests and mammography when performed with another service	100%
Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	100%
CT scans, MRIs, MRAs and PET scans	$50 *copayment*
Therapy Services	100%
Includes *short-term rehabilitative therapies* and *other therapies* including dialysis; see "Physician Office Services" for visit maximums.	
***Inpatient Hospital* Services**	
Physician Services	100%
***Hospital* and *Hospital*-based Services**	$275 per admission *copayment*, then 100%
Includes maternity delivery, prenatal and post-delivery care. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new *deductible* for *covered services* from *doctors* or *other professional providers.*	
Skilled Nursing Facility	100%
Maximum of 60 days per *benefit period.*	

In-network

Other Services 100%

Includes *ambulance, durable medical equipment, hospice* services, *medical supplies,* orthotic devices, private duty nursing, *prosthetic appliances,* and *home health care.* Orthotic devices for correction of *positional plagiocephaly* are limited to a *lifetime maximum* of $600.

Lifetime Maximum

The following maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.

Lifetime Maximum Unlimited

Unlimited for all services, except orthotic devices for *positional plagiocephaly* and substance abuse.

Penalty For Failure To Obtain *Certification*

Certain services require *prior review* and *certification* by BCBSNC in order to receive benefits. You are responsible for requesting or ensuring that your *provider* requests *prior review* by BCBSNC. **Failure to request *prior review* and receive *certification* may result in allowed charges being reduced by 50% or full denial of benefits. See "Prospective Review/*Prior Review*" in "*Utilization Management*."**

Prior review and *certification* by Magellan Behavioral Health are required for *inpatient* and *outpatient* mental health and substance abuse services, except for *emergencies*. Please see the number in "Whom Do I Call?"

SUMMARY OF BENEFITS *(cont.)*

	In-network
Mental Health And Substance Abuse Services	
Prior review and *certification* by Magellan Behavioral Health are required for *inpatient* and *outpatient* services. Please see the number in "Whom Do I Call?"	
Mental Health Office Services Limited to a maximum of 30 *office visits* per *benefit period*.	$40 *copayment*
Mental Health *Inpatient/Outpatient* Services Limited to maximum of 30 days per *benefit period*.	100%
Substance Abuse Office Services	$40 *copayment*
Substance Abuse *Inpatient/Outpatient* Services	100%
Substance Abuse *Benefit Period Maximum*	None
Substance Abuse *Lifetime Maximum*	$16,000

Prescription Drug Program Guide for Duke Energy Medical Plan

medco® manages your prescription drug benefit for Duke Energy.

Prescription Drug Program

The Duke Energy Medical Plan options include outpatient prescription drug coverage currently administered by Medco Health Solutions, Inc. ("Medco"). Medco is a national pharmacy benefit manager with participating retail pharmacies that include Wal-Mart, Rite Aid, Walgreens, CVS, and others. The prescription drug program can help you save on medically necessary prescribed medications at retail pharmacies and through **Medco By Mail**, a home delivery pharmacy service.

Through the prescription drug coverage, you can:

- Purchase up to a 30-day supply of prescription medications at a participating retail pharmacy.
- Use **Medco By Mail** for up to a 90-day supply of prescription medications.
- Use online resources at www.medco.com to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- Reach Medco Member Services representatives, 24 hours a day, 7 days a week (except Thanksgiving and Christmas when holiday schedules apply) at 1-800-987-8361. Pharmacists are also available around the clock for medication consultations.

Medical Plan and Health Care Spending Account

(Applicable only to active employees)

The prescription drug program copays do not apply to your Medical Plan deductible or coinsurance maximum, if applicable. 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 amounts and copays with before-tax dollars by filing for reimbursement from your HCSA, using your HCSA debit card, or through the HCSA automatic reimbursement feature.

Retail Prescription Drug Program Deductible for Catastrophic Coverage Option

(Applicable only to certain retirees)

If you are enrolled in the Medical Plan's Catastrophic B coverage option, each covered individual has a $200 annual individual retail prescription drug deductible for prescription purchases made at participating retail pharmacies. The $200 deductible is separate from the Medical Plan's Catastrophic B coverage option deductible. Each covered person must meet the annual deductible before the prescription drug program copays apply to retail prescription drug purchases for that person. When you make retail prescription drug purchases at a participating pharmacy that are applied toward the prescription drug annual deductible, you will pay 100% of Medco's negotiated price for the medication that you are purchasing. When you reach the point where the amount of a prescription drug purchase will allow you to meet your annual deductible, you will pay the remaining amount of the deductible and the applicable copay amount.

For example, if the amount of your prescription purchase is $90 and there is $25 remaining to meet your annual deductible, you will pay $25, which is applied to the deductible, and the applicable copay amount for the purchase of the prescription drug.

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 for each person. You may also call Medco's Member Services to determine the portion of the deductible that has been satisfied to date.

If you are enrolled in any option other than the Medical Plan's Catastrophic B option, you are not required to satisfy an annual deductible before the prescription drug program copays apply to retail prescription drug purchases.

Formulary

Your prescription drug program includes a tiered formulary. A formulary is a list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings for the member and the Medical Plan. Due to the tiered formulary, your copay amount for prescription purchases will vary depending on whether your physician prescribes a generic, preferred brand-name or non-preferred brand-name medication. By asking your physician to prescribe generic or preferred brand-name medications, you can help control rising health care costs.

To find out whether a medication is included in the tiered formulary, visit Medco online at www.Medco.com. If you are a first time visitor to the site, please take a moment to register. Please have your member ID number available. After you log in, click "Learn about formularies" in the "Prescriptions & benefits" section. Search for a specific drug to determine if it is on the formulary. A formulary guide is included in your Medco Welcome Kit and you may also call Medco Member Services and request that a formulary guide be mailed to your home. See the prescription drug program summary of benefits for more information about applicable copays for generic, preferred brand-name and non-preferred brand-name medication.

Filling Your Prescription at a Retail Pharmacy

You can fill a prescription at a retail pharmacy for up to a 30-day supply. You will simply show your Medco ID card (with the Medco group number) at the time of your purchase. After meeting any applicable deductibles, you will pay the applicable prescription drug copay.

- If you don't identify yourself to the pharmacist as a Medco participant, or if you go to a non-participating pharmacy, you will have to pay the full price when you pick up the prescription and then submit a paper claim to Medco for reimbursement. You will be reimbursed based on the Medco negotiated price for the medication, less any required deductible and copay. Retail pharmacies that participate in the Medco retail pharmacy 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 Medco 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 participating retail pharmacy and do not identify yourself as a Medco participant by presenting your Medco 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 Medco ID card and ask the pharmacist to submit the order using the original dispensing date. Please confirm that 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 copay. This process will eliminate your need to submit a paper claim to Medco for reimbursement.

Retail Refill Allowance (Mandatory Mail) After Three Retail Refills

Generally, a 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 the Medical Plan's prescription drug program, you must use **Medco By Mail** to receive prescription coverage benefits for your maintenance medication purchases. Here's how it works:

- Beginning with the 4th retail fill of a covered maintenance medication, you will pay the entire cost of that maintenance medication if you continue to purchase it at a participating retail pharmacy. However, if you use Medco's mail-order service, **Medco By Mail**, you will pay the applicable mail order copay amount for up to a 90-day supply.
- The first three times that you purchase each maintenance medication at a participating retail pharmacy, you will pay your participating retail pharmacy copay (for members enrolled in the Medical Plan's Catastrophic B coverage option, the deductible must be met before the copay will apply). After that, you will pay the entire cost of each maintenance medication unless you choose to order through **Medco By Mail**.
- You should continue to purchase your prescriptions for short-term use, such as antibiotics, at a participating retail pharmacy. You'll pay the applicable participating retail pharmacy copay for up to a 30-day supply.

The list of maintenance medications that are addressed by the Retail Refill Allowance provision is subject to change at any time. Visit **www.medco.com** and click "Price a medication" to find out whether your medication is considered a maintenance medication and whether it is affected by any plan limits, or you may call Medco directly for more information.

Using Medco By Mail

The prescription drug program includes **Medco By Mail**, a home delivery pharmacy service, which offers a greater discount on the cost of maintenance medication and a larger supply (up to a 90-day supply) per prescription. Refer to the Retail Refill Allowance section above for a description of what constitutes a maintenance medication. To use **Medco By Mail**:

1. Ask your physician to prescribe your maintenance medication for up to a 90-day supply, plus refills for up to one year, if appropriate.
2. Mail your prescription, along with an order form and the required copay, to Medco. Order forms are available online on the Duke Energy Portal and at **www.medco.com**, or you may call Medco to request a supply of order forms.
3. Once you have established your prescription through **Medco By Mail**, you can order refills online. You will need to enter your member number (from your Medco ID card), enter the prescription number for the medication you wish to refill and verify your address. A detailed summary of your order, including costs, will be available for viewing online. Similar information will be included with your prescription when it is mailed to you.
4. You may also ask your physician to call **1-888-EASYRX1 (1-888-327-9791)** for instructions on how to fax the prescription. Remember to give your physician your Member ID and Medco group numbers (as shown on your Medco ID card); both numbers will be required for your prescription order.

If your prescription is written for less than a 90-day supply, the prescription will be filled in accordance with the day supply your physician ordered, but you will pay the entire **Medco By Mail** copay. If the medication is a federal legend, maintenance medication, a Medco pharmacist will review the prescription

and notify you if the prescription is less than the maximum days' supply available at mail. The pharmacist will offer to contact your physician on your behalf to obtain a new prescription. Please note there are certain situations that may preclude the pharmacist from contacting you directly, such as if the medication is a controlled substance, a specialty drug, or a compounded prescription.

Your prescription will be delivered to your home within 14 calendar days. With a **Medco By Mail** prescription, you will receive materials explaining the purpose of the drug, correct dosages and other helpful information. **When a prescription is ordered using Medco By Mail, Medco will automatically dispense the generic equivalent if one is available and permissible by law, unless your physician has indicated that substitution is not allowed.**

Send mail order prescriptions to:
Medco Mail Order Pharmacy
PO BOX 650322, Dallas TX 75265

Accredo Health Group – Medco's Specialty Care Pharmacy

Specialty medications are typically injectable medications administered either by you or a healthcare professional, and they often require special handling.

Conditions and therapies for which specialty medications are typically used include:

- Age-related macular degeneration
- Alpha-1 proteinase deficiency
- Anemia
- Anti-infective therapy
- Asthma
- Cancer
- Cystic fibrosis
- Deep vein thrombosis
- Fabry disease
- Gaucher disease
- Growth hormone deficiency
- Hemophilia
- Hepatitis C
- Hereditary tyrosinemia
- HIV
- Hyperparathyroidism
- Immune deficiency
- Infertility
- Insulin-like growth factor therapy
- Iron chelation therapy
- Mucopolysaccharidosis
- Multiple sclerosis
- Neutropenia
- Osteoarthritis
- Osteoporosis
- Parkinson disease
- Pompe disease
- Psoriasis
- Pulmonary hypertension
- Respiratory syncytial virus
- Rheumatoid arthritis

Under your prescription drug program, some specialty medications may *not* be covered at participating retail pharmacies or through **Medco By Mail**, but instead may only be covered when ordered through ***Accredo Health Group***, Medco's specialty care pharmacy. Accredo is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling. Services include:

- Toll-free access to specially trained pharmacists 24 hours a day, 7 days a week
- Personalized counseling from our dedicated team of registered nurses and pharmacists
- Expedited, scheduled delivery of your medications at no extra charge
- Refill reminder calls

- Coordination of home care and other healthcare services
- Free supplies, such as needles and syringes, to administer your medication

To find out whether any of your specialty medications need to be ordered through Accredo, please call Medco Member Services at the toll-free number on your prescription drug ID card.

Medicare Part B Medications

(Applicable only to Medicare Part B enrollees)

If you are eligible for Medicare Part B coverage and use a participating Medicare Part B retail pharmacy, you may not have to incur out-of-pocket expenses for your Medicare Part B-eligible medications and supplies*. Medicare Part B-eligible prescriptions may be filled through the **Medco By Mail** mail-order pharmacy or at a participating Medicare Part B retail pharmacy. In either case, the pharmacy will verify coverage and file your prescription claims with Medicare, and bill you if any balance is due. For more information about Medicare Part B coverage, call Medco Member Services toll-free at 1-800-987-8361, or visit **www.Medco.com.**

**Medicare Part B coverage will begin only after you have paid your Medicare deductible.*

Some of the medications and supplies typically covered by Medicare Part B include:

- Diabetic supplies (test strips, meters)
- Medications to aid tissue acceptance from Medicare-covered organ transplants
- Certain oral medications used to treat cancer
- Certain medications used in situations where the kidneys have completely failed

If you have Medicare Part B coverage, you will be able to fill prescriptions like these in one of two ways:

- **Medicare Part B Mail-Order Pharmacy**—When using mail order for your medication or supply needs, you will initially send your prescription to **Medco By Mail**. Then, depending on the type of medication or supply requested, **Medco By Mail** will transfer your prescription information to one of two Medicare Part B participating mail-order pharmacies—**Liberty Medical** or **Accredo Health Group**, Medco's specialty care pharmacy. Both Liberty and Accredo have extensive experience with Medicare Part B and will support the dispensing and billing of your prescriptions. They will verify coverage, file your prescription claim with Medicare, and bill you for any balance due. Depending on the covered medications or supplies that you need, Liberty or Accredo will mail your Medicare Part B medications and supplies directly to you and provide instructions for obtaining refills.
- **Medicare Part B Retail Pharmacy**—When using a participating 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 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 Coordination of Benefits processing is available and coordinated by the Part B providers. The provider will submit claims on behalf of the member to Medicare for processing as primary. Once payment is received from Medicare, the Part B provider will submit a secondary claim to Medco and the claim will process under the secondary benefit, if that is offered (for example, Medicare would pay 80% of the claim as primary, and the client would pay 20% of the claim as secondary).

A word about prescriptions covered by Medicare Part B
For more details about which medications or supplies are Medicare Part B–eligible and to learn more about your Medicare coverage:

- Visit the Medicare website at **www.medicare.gov**.
- Call Medicare Customer Service at **1 800 MEDICARE** (1 800 633-4227).

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 **Medco By Mail** or at a participating retail pharmacy (using your Medco 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.

Generic Drugs

For prescription medications, the brand-name is the product name under which a drug is advertised and sold. Generic equivalent medications contain the same active ingredients and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name counterparts. Generally, generic drugs cost less than a brand-name drug. Whenever appropriate, you should ask your physician to prescribe generic drugs. Sometimes your physician may prescribe a medication as "dispense as written" when a preferred brand-name or generic equivalent drug is available. As part of your prescription drug program, the pharmacist may discuss with your physician whether an equivalent generic or preferred brand-name drug might be appropriate for you. The final decision on your medication always rests with you and your physician, even if that decision results in a higher cost to you for your prescription medication.

Covered Expenses

The following are covered expenses unless listed as an exclusion below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes (covered at a $0 copay)
- Over-the-Counter (OTC) Diabetic Supplies (lancets, insulin syringes and needles are covered at $0 copay)
- Oral, Transdermal, Intravaginal and Injectable Contraceptives
- Drugs to Treat Impotency (all dosage forms except Yohimbine) for males age 18 and over
- Yohimbine (covered without the limits that exist for other impotency products)
- Inhaler Assisting Devices
- Peak flow meters
- Synagis/Respigam
- Hemophilia Factors
- Fertility Agents (100% covered after standard copay, up to $2500 per person per lifetime, then member pays 50% of the cost of the drug)
- Zyban and Chantix (limit of 180 days of therapy per year and 360 days of therapy per lifetime)

- Substance abuse treatments
- Dental Fluoride Products
- Anti obesity Agents (covered **Medco By Mail** only)
- Products packaged as greater than a 30 days supply are covered at mail only

Coverage limits for Certain Medications

Your prescription drug program may have certain coverage limits. For example, some quantities may be limited or some prescriptions require a coverage review. Examples of drugs with limitations or requiring coverage review are Provigil, Human Growth Hormones, Impotency Products, and Proton Pump Inhibitors (Prevacid, Protonix, Aciphex, Zegerid). Refer to www.Medco.com or call member services at 1-800-987-8361 for details.

Dispensing Limits

- The amount of drug which is to be dispensed per prescription or refill (regardless of dosage form) will be in quantities prescribed up to a 30-day supply at a participating retail pharmacy and up to a 90-day supply through **Medco By Mail**
- Thalomid limited to a 28 day supply at both retail and **Medco By Mail**

Excluded Expenses

The following are excluded from coverage 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 under the Medical Plan)
- Glucowatch Products
- Anti-obesity meds at retail
- 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
- Biologicals, Immunization agents or Vaccines
- Blood or blood plasma products
- 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 any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member
- 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

Coordination of Benefits for the Prescription Drug Program

Under the prescription drug program, Medco 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 deductible and coinsurance, you may want to use your Medco ID Card, instead of your spouse/domestic partner's plan, to obtain your prescriptions.

Please Note: Medco does coordinate benefits for Medicare Part B. Please see section titled "Medicare Part B Medications" for more details.

How to File a Prescription Drug Program Claim

When you fill your prescription at a participating retail pharmacy and identify yourself as a Medco 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, if any, and the copay.

If you do not identify yourself to the pharmacist as a Medco participant, or if you do not use a participating pharmacy, you will need to file a claim for reimbursement of your prescription drug expenses through Medco. 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, the cost, the strength, quantity, and days supply of medication, the name of the medication, prescription number and NDC number. When you submit an original receipt, keep a copy for your records. Claim reimbursement is limited to Medco's discounted price less any required deductible and copay. Medco 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 prescription medication on January 15, 2009, from a non-participating pharmacy, you must file your claim by April 15, 2010, to receive reimbursement for your expenses. Duke Energy offers new Medco prescription participants a 45-day grace period for prescription drug claims purchased at full cost in situations where the prescription ID card was not used. The grace period allows members to be reimbursed at 100%, less the applicable deductible and copay, for paper claims submitted within 45 days from a participant's initial eligibility effective date with Medco. For example, a participant who's initial effective date with Medco is January 1, 2009 would have 45 days (until February 14, 2009) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether the pharmacy was a participating or non-participating.

To obtain a claim form, call Medco Member Services at 1-800-987-8361, or go online to **www.medco.com**.

Submit claim forms to:
Medco Health Solutions, Inc.
PO Box 14711
Lexington, KY 40512

Reviews & Appeals

Medco will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Medco's control, it will notify you or your representative within 15 days after receiving the request. The extension notice will include 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 Medco 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 45 days to respond to the request for information.

Notice of Adverse Determination

In the event of an adverse benefit determination, in whole or in part, you (or your authorized representative) 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 plan benefit. An adverse benefit determination notification for any prescription drug plan claim will contain:

- 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 review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; and
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim.

When You Have a Complaint or an Appeal

If your claim is denied, you may request a full review by Medco within 180 days of the date of the adverse benefit determination. Your written letter of appeal should include the following:

- your name and member 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 Medco 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 Medco in reviewing your claim. You may request reasonable access to copies of all documents, records, and other information relevant to your claim. Medco 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. Your appeal should be mailed to:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving TX 75063
1-800-987-8361

Medco will notify you of its decision on your appeal within 15 days of its receipt of your 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:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and the claimant's right to bring an action under ERISA section 502(a);
- upon request and free of charge, reasonable access will be provided to copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal.

Second Level Appeal Process

If your claim is denied on appeal, you have a right to bring a second 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. Medco 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.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or Duke Energy 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.

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 Appeals Procedure. You may not initiate a legal action until you have completed the first and second level 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

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 Medco's 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 Medco at the address listed above.
Call Medco Member services for additional information regarding the appeals process.

This is a guide of covered expenses and expenses not covered under the prescription drug program. For more information about applicable deductibles, copays and plan limits, please call Medco Member Services or visit www.Medco.com. For more detailed information on the Medical Plan, refer to the Duke Energy Medical Plan General Information Booklet and BCBSNC Benefits Booklet sections of this Summary Plan Description. The official plan documents govern plan provisions and payment of plan benefits.

medco®

SUMMARY OF PRESCRIPTION DRUG BENEFITS

Annual Deductible (per person*) – *applies to retail pharmacy purchases*	$0	
Prescription Drug Co-pays		
You must show your Medco ID card	**Retail Pharmacy (up to a 30-day supply)**	**Mail Order (up to a 90-day supply)**
Generic	$15	$38
Preferred Brand	$30	$75
Non-Preferred Brand	$60	$150

*There is no annual family prescription drug deductible.

Medical Plan Benefits

Enhanced Out-of-Area (OOA) option

Duke Energy®

Inside you will find:

- SECTION I: Duke Energy Medical Plan—General Information
- SECTION II: BCBSNC Benefit Booklet (includes Summary of Medical Benefits)
- SECTION III: Medco Prescription Drug Guide
- SECTION IV: Summary of Prescription Drug Benefits

The Duke Energy Medical Plan
General Information

IMPORTANT NOTICE

This General Information booklet for The Duke Energy 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 election 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 2009 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

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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, pharmacy, wellness and disease management benefits.

Based on your location and employee or retiree group, there are various Medical Plan coverage options available, such as exclusive provider organization (EPO), preferred provider organization (PPO) and high-deductible health plan (HDHP) options. If you do not have adequate access to network providers, you may qualify for out-of-area (OOA) options that mirror the PPO options. All of the Medical Plan options are designed to help you pay for health care expenses.

myHR Service Center

If you have any questions about the Medical Plan or the information in this General Information booklet, contact the myHR Service Center at 1-888-465-1300. Representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time. Information is also available through the Your Benefits Resources™ (YBR) Web site 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 (collectively referred to with Duke Energy as the "Company") 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.

International Assignment

When you are assigned by your Company to work outside the U.S. for a period that is initially expected to last at least nine consecutive months, you will cease to be eligible for the Medical Plan options available to employees on U.S. domestic assignment.

Instead, you will be eligible for the Medical Plan's special international assignment coverages. These coverages are described in a special booklet and not in the Medical Plan's General Information booklet or the other Medical Plan booklets.

Eligible Retirees

If your employment terminates on or after January 1, 2009, to be eligible for retiree coverage under the Medical Plan, at termination of employment you must:

- be employed by a Company that offers access to retiree coverage under the Medical Plan; and
- be at least age 50 and credited with at least 5 years of retiree eligibility service.

Contact the myHR Service Center if you want to know if a particular Company offers access to retiree coverage under the Medical Plan.

If your Company employment terminated before January 1, 2009, 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 for your eligible spouse and/or child(ren). If you are a Legacy Duke employee[†] who retires on or after January 1, 2006, you may be eligible to elect coverage for your eligible domestic partner. If you are a Legacy Duke employee who retired before January 1, 2006, or if you are a Legacy Cinergy retiree[‡], you are not eligible to elect coverage for your domestic partner. Please refer to the sections *Enrolling in the Medical Plan – Eligible Retirees* and *Mid-Year Coverage Changes* for additional information.

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)[*]

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."

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, which may include "common law marriage," and the spouse must meet the federal tax requirement of being a person of the opposite sex who is the taxpayer's husband or wife.

[†] When used in this booklet, the term "Legacy Duke" refers to an individual who (1) terminated employment with Duke Energy Corporation, a North Carolina corporation, and its affiliates prior to the merger of Cinergy Corp. and Duke Energy Corporation, a North Carolina corporation, (2) was employed by Duke Energy Corporation, a North Carolina corporation, and its affiliates immediately prior to such merger or (3) except as provided in footnote 2 below, was hired following such merger by a payroll company that was affiliated with (or has been designated as having been affiliated with) Duke Energy Corporation, a North Carolina corporation, immediately prior to such merger.

[‡] When used in this booklet, the term "Legacy Cinergy" refers to an individual who (1) terminated employment with Cinergy Corp. and its affiliates prior to the merger of Cinergy Corp. and Duke Energy Corporation, a North Carolina corporation, (2) was employed by Cinergy Corp. and its affiliates immediately prior to such merger, (3) was hired following such merger by a payroll company that was affiliated with (or has been designated as having been affiliated with) Cinergy Corp. immediately prior to such merger or (4) was hired by Duke Energy Business Services, LLC on or after July 1, 2008 at a work location such that he or she would have been employed by Duke Energy Shared Services, Inc. if he or she was hired to work at such location immediately prior to July 1, 2008 and he or she is so designated as Legacy Cinergy in accordance with rules prescribed by the Plan Administrator.

[§] See *Eligible Retirees* for information regarding eligible retirees' ability to elect coverage for a domestic partner.

[*] A child of divorced parents will generally be recognized by Section 152(e) of the Internal Revenue Code as a dependent of both parents for purposes of coverage under the Medical Plan.

By enrolling a spouse, you represent that the individual meets these requirements. You must immediately drop coverage for a spouse who no longer meets these requirements.

Domestic Partner Eligibility

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

- be in an ongoing, exclusive and committed relationship with one another of mutual caring and support, in which each is responsible for the other's welfare and which is intended to continue indefinitely;
- be at least 18 years old and mentally competent to enter into a legal contract;
- reside together in a joint household for the preceding 6 consecutive months;
- share financial obligations of, and be jointly responsible for, the joint household;
- not be legally married to or legally separated from anyone else, and not be in a domestic partnership with anyone else; and
- not be blood relatives to a degree where marriage would be prohibited.

Child Eligibility

Your child is:

- your biological child; **or**
- your legally adopted child, including a child placed in your home for adoption by you as long as the child remains in your home and the adoption procedure has not been terminated (a legally adopted child will not qualify as a dependent if the child has reached age 18 as of the date of adoption or placement for adoption); **or**
- a stepchild for whom you or your spouse has full or joint custody or managing conservatorship; **or**
- any other child related to you by blood or marriage or for whom you or your spouse has court-appointed legal guardianship or managing conservatorship, who is living in your household on a substantially full-time basis, who you claim as a dependent for federal income tax purposes, and with whom you have a regular parent/child relationship.

In addition to meeting the above requirements, a child must also meet the following eligibility criteria:

- Unmarried; **and**
- Primarily dependent on you for support; **and**
- Less than age 19 if not a full-time student; **or**

** See *Eligible Retirees* for information regarding eligible retirees' ability to elect coverage for a domestic partner.

- Less than age 25 if a full-time student at an accredited educational institution taking nine or more hours per term; **or**
- Any age if he or she became physically or mentally incapable of self-support while enrolled in the Medical Plan and before reaching the applicable limiting age of 19 or 25 and continuously remains incapacitated and enrolled in the Medical Plan; **or**
- Any age if he or she was physically or mentally incapable of self-support on your date of employment with the Company, was enrolled in the Medical Plan as of your employment date and continuously remains incapacitated and enrolled in the Medical Plan.

In addition, your child must meet the Internal Revenue Code requirements for tax-free health coverage to be eligible for coverage in the Medical Plan.

By enrolling a dependent child, you represent that the individual satisfies these requirements. You must immediately drop coverage for a dependent child who no longer meets these requirements.

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

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

You may be required to provide evidence of dependent eligibility, such as, but not limited to, a marriage license, divorce decree, birth certificate, court order, adoption papers, certificate/affidavit of common-law marriage or proof of joint residency. Verification of a dependent child's full-time student status may be requested at age 19 and each year beyond age 19.

To continue coverage beyond age 19 for a child who is physically or mentally incapable of self-support, you must provide evidence of your child's incapacity to the applicable Claims Administrator. The application can be obtained by contacting the 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 graduates from college), the individual(s) who become(s) ineligible for coverage will be dropped from your coverage.

You must immediately report that any dependents 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 myHR Service Center that your dependent is no longer eligible.

If you do not inform the 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 elections (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 elections);

- 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, go to the myHR link on the Duke Energy Portal or contact the 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 – Eligible Employees

When You Are First Eligible

When you are eligible to enroll as an employee, you will make your Medical Plan elections 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 elections, contact the 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.

You may also decline coverage altogether.

During Annual Enrollment

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

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, 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).

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 election change occurs (see *Mid-Year Coverage 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 life event for which you can make a change in your Medical Plan elections (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.

Enrolling in the Medical Plan – Eligible Retirees

When You Are First Eligible

If you are an eligible retiree as described in *Eligible Retirees*, 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[††];
- Individual + Child(ren); or
- Individual + Family (spouse and child(ren))

You must make your election within 31 calendar days of becoming eligible for retiree coverage.

When you are eligible to enroll as a retiree, you can make your Medical Plan elections using an online enrollment tool. You will receive additional information about the online enrollment tool when you become eligible. You can also make your Medical Plan elections by contacting the myHR Service Center.

If you have any questions or need assistance in making your enrollment elections, contact the myHR Service Center.

[††] See *Eligible Retirees* for information regarding your ability to elect coverage for a domestic partner.

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 election 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 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 election changes are allowed.

Please refer to *During Annual Enrollment* and *Mid-Year Coverage Changes* for additional information.

During Annual Enrollment

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

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. When your employment terminates, you may reelect retiree coverage; however, unless you were represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA, you will not receive additional service credit for the time you worked as an active employee after your rehire date for purposes of determining your eligibility for or the amount of any Company contribution towards the cost of retiree medical coverage, either in the form of subsidized monthly coverage under the Medical Plan or Health Reimbursement Account benefits.

Cost of Coverage

Active Employees

If you are an active employee, 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 Web site.

Paying for Coverage as an Active Employee

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 a domestic partner under the Medical Plan is deducted on a pre-tax basis. On pay advice statements, the contribution amount for your coverage will appear as a pre-tax deduction and the contribution amount for your domestic partner will appear as imputed income.

While the Company subsidy amount for domestic partner coverage under the Medical Plan is the same as for spousal coverage, the subsidy amount for domestic partner coverage is reported each pay period as imputed income to the employee and is subject to applicable taxes.

Non-tobacco user discounts may be available for certain active employee Medical Plan coverage options. To qualify for applicable non-tobacco user discounts, you and all covered dependents must not have used tobacco products, including smokeless tobacco, during the 12 months prior to the effective date of your coverage. When you enroll, you will be asked to indicate if the non-tobacco user discount applies.

Non-Tobacco User Discount – Alternate Procedure for Active Employees in Certain Medical Plan Options

If you (or your covered dependent) are unable, due to a medical condition, to meet the requirements for the non-tobacco user discount (or if it is medically inadvisable for you to attempt to meet the requirements for the non-tobacco user discount), you may still apply to receive the discount by providing these two items:

1. A written statement from your (or your covered dependent's) physician stating that you (or your covered dependent) have a medical condition that makes it unreasonably difficult (or medically inadvisable) for you (or your covered dependent) to meet the requirements for the non-tobacco user discount. This statement should identify the health factor, explaining why the health factor makes it unreasonably difficult (or medically inadvisable) for you (or your covered dependent) to meet the requirements for the discount, and recommending a specific tobacco-cessation program that is appropriate for you (or your covered dependent), and
2. Either of the following:
   - A written statement from the recommended tobacco-cessation program stating that you (or your covered dependent) are either currently enrolled or that you (or your covered dependent) have completed the program within the last 12 months, or
   - If it is your initial year of claiming the discount in accordance with this procedure, a written certification from you that you (or your covered dependent) will enroll in the tobacco-cessation program recommended by your (or your dependent's) physician within the next three months.

In order to continue the non-tobacco user discount under this procedure, a new physician's statement and a new tobacco cessation program's statement will be required each year. In order

for you to qualify for the non-tobacco user discount, you and each of your covered dependents will have to meet the requirements for the discount or satisfy the alternate procedure.

If you would like to apply for the non-tobacco user discount under the alternate procedure, you should indicate at enrollment that you are a tobacco user and then contact the myHR Service Center to discuss remitting the information required under the alternate procedure. All information must be received within 31 calendar days of the date you become an eligible employee or, in the case of enrollment during a future annual enrollment period, by the deadline communicated in your annual enrollment materials. You will pay tobacco user rates until your alternate procedure application has been approved, at which time the non-tobacco user discount will be applied on a prospective basis as soon as administratively practicable.

Retirees

If you are an eligible retiree, the cost of your retiree coverage under the Medical Plan is based on the Medical Plan coverage option that you elect and the eligible dependent(s) you choose to cover. The portion of that cost that you must pay depends on multiple factors, including your date of hire, your date of termination and your retiree group. As described below, you may be eligible for a Company contribution towards the cost of retiree medical coverage, either in the form of subsidized monthly coverage under the Medical Plan or Health Reimbursement Account benefits. Information about contribution amounts is available through the YBR Web site.

If you were hired before January 1, 2009, you may be eligible for a Company contribution towards the cost of retiree medical coverage if you terminate employment after satisfying all applicable requirements. Your eligibility for Company contributions is governed by the eligibility rules in effect at the time of your date of 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 hired on or after January 1, 2009 (including most rehired employees) and you subsequently terminate your employment with the Company as an eligible retiree, you will not be eligible for a Company contribution toward the cost of retiree medical coverage and will be responsible for paying the full cost of any retiree coverage you elect under the Medical Plan, unless you are represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA, in which case the rules directly above for individuals hired before January 1, 2009 continue to apply to you.

If you are rehired on or after January 1, 2009 and you subsequently terminate your employment with the Company as an eligible retiree, you will be eligible for a Company contribution towards the cost of retiree medical coverage only if you satisfied the eligibility requirements for Company contributions toward the cost of retiree medical coverage in effect at the time of your previous 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. The rules described in this paragraph do not apply to individuals represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA. If you are represented by one of these unions, the rules directly above for individuals hired before January 1, 2009 continue to apply to you.

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.
- You also have the option to pay contributions in advance for the quarter (three months); semi-annually or for the entire year. If you later drop coverage for any reason, your unused contributions will be refunded. Contact the myHR Service Center to set up alternate billing arrangements.
- 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 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 myHR Service Center.

If you would like to change your payment method, contact the myHR Service Center.

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 are two months behind but have been sending in partial payments, or
- you call the 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.

Reinstatement after non-payment is possible if you contact the 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.

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 elections as a newly eligible employee or retiree, coverage begins on the date you become eligible (assuming that you make your elections within 31 calendar days of becoming eligible). Deductions for your contributions (or payment for your

coverage, in the case of eligible retirees) begin as soon as administratively practicable following the date that you make your elections.

Mid-Year Coverage Changes

As a covered active employee or retiree, 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 that 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 myHR link located on the Duke Energy Portal or by contacting the myHR Service Center.

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

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 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 myHR Service Center within 31 calendar days of a loss of eligibility.

If you are eligible to make changes, the elections 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 marries or turns 19 and is not a full-time student)

- a QMCSO is received*
- your child dies

- You begin or end an international assignment scheduled for at least nine months
- 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
- You or your dependent's COBRA coverage from another employer expires
- You or your dependent becomes entitled to or loses Medicare or Medicaid*
- 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

When Mid-Year Election and Contribution Changes Are Effective

The following chart shows when coverage and contributions change if you notify the myHR Service Center of a work/life event within 31 calendar days of the event.

Election Change	Coverage	Contributions
Start or increase coverage	Coverage changes on the day the work/life event occurred (Event Date)	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*
Decrease or stop coverage (your elective decrease or coverage termination)**	Coverage changes on the first day of the month after your Election Date*	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*
Decrease coverage due to a covered individual becoming ineligible for coverage (for example, divorce, child is age 19 and not a full-time student)***	Coverage for individuals no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage (Event Date)	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*

* Court Orders. 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 may also make an election change to cancel medical coverage for the child if the order requires the child's other parent to provide coverage.

* 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.

Election Change	Coverage	Contributions
* Your Election Date is the date you submit your election changes. **Does not include termination of employment. *** Does not include death. If you die, coverage ends on the date of your death.		

Situations Impacting Your 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 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 Insurance Plan or pay under the Sick Time Pay Benefit, you may be eligible for continued coverage under the Medical Plan. Contact the 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, your Medical Plan coverage will continue as long as you remain an eligible employee and pay any required contributions, and your coverage will be primary to Medicare.

If You Become Entitled to Medicare

If you are not actively at work and you become entitled to Medicare, you will be required to enroll in an option that coordinates with Medicare. Contact the 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 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 or as an eligible retiree;
- the last day of the month in which you cease to be an eligible employee, 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 the Company informs the Claims Administrator that you (while you are still eligible) are canceling Medical Plan coverage; or
- when 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. Medical Plan coverage will actually terminate, but will be reinstated retroactive to the coverage termination date if your 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.

When your coverage ends, you will receive a certificate of coverage that indicates the length of time you had coverage under the Medical Plan to the extent required by applicable law. You may need this certificate of coverage when enrolling in another plan. With this certificate, the time you were covered may be credited toward any pre-existing condition limitations in your new plan, provided you are enrolled in the new plan within 63 days of losing your Medical Plan coverage.

Benefits if You Die

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 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 myHR Service Center.

This provision applies even if your spouse 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 that any dependents 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 when your spouse/domestic partner either does or does not report a dependent's loss of eligibility within 31 calendar days of the loss of eligibility. To drop coverage for ineligible dependents, your spouse/domestic partner should go to the YBR Web site or contact the myHR Service Center.

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.

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, go to the myHR link on the Duke Energy Portal or contact the myHR Service Center.

If You Leave the Company

If your employment with the Company terminates, your coverage under the Medical Plan will end, unless you elect to continue coverage under COBRA or as an eligible retiree.

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

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 COBRA continuation coverage under the terms of COBRA, to maintain consistent administration, Duke Energy will apply the same rules to a domestic partner as to a spouse.

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,
- entitlement to Medicare, 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*.)

Bankruptcy Proceeding

If you are a retired employee and you or your eligible dependents lose coverage resulting from a bankruptcy proceeding against your Company, you may qualify for continuation coverage under COBRA.

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. The disability must last at least until the end of the 18-month period of continuation coverage.

You must notify the myHR Service Center in writing within the initial 18-month coverage period and within 60 days of the Social Security Administration's determination. Your verbal notice is not binding until confirmed in writing and the myHR Service Center receives a copy of the Social Security disability determination. You must also notify the 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, 2009, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2010, 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, 2012; or
- 18 months following your termination of employment - July 1, 2011

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2012 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 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 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;
- you become entitled to Medicare;
- you or an eligible dependent is determined to be disabled by the Social Security Administration

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

Duke Energy'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 will also 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 used 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 will also affect continued coverage under COBRA. You will be notified prior to 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. (If the other plan limits coverage of a pre-existing condition, COBRA coverage may be continued in certain circumstances).

Pre-existing Condition Limitation

If you become covered under another group medical plan and are affected by a pre-existing condition limitation under that plan, COBRA coverage may continue for that condition until you have satisfied the pre-existing condition limitation, as long as you remain within the COBRA period. When you are eligible for full benefits under your new plan, your COBRA coverage will be terminated.

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.

Medical Child Support Orders

If the Company receives notification that, as a result of a Qualified Medical Child Support Order, 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 may also sign claim forms and assign benefits to providers. The Claims Administrator will send notification of payment to 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 these guidelines:

- 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.
- 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
526 South Church Street
Charlotte, NC 28202
704-594-6200
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 plan number assigned to the Medical Plan is 502.

Funding

Benefits under the Medical Plan generally are provided from funds held by trustees. All Medical Plan claims except for post-retirement coverage for non-key employees are paid from the Duke Energy Corporation Welfare Benefits Trust VEBA I with Mellon Bank NA as trustee. Claims for post-retirement coverage for non-key employees are paid from the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II with Mellon Bank, NA as trustee. The address for Mellon Bank, NA is:

Mellon Bank, NA
One Mellon Bank Center
Pittsburgh, PA 15258

The Company may also provide benefits under the Medical Plan through insurance or from its general assets, and may also transfer assets from the 401(h) retiree account under the Duke Energy Corporation Master Retirement Trust to the Medical Plan to provide benefits for post-retirement coverage for non-key employees.

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy 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 the Claims Committee, which serves 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 and the Claims Committee may be contacted as follows:

Benefits Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285
704-594-6200

Claims Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285
704-594-6200

The Benefits Committee has appointed the Claims Administrators, which 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 can also obtain additional information by contacting the myHR Service Center.

The Benefits Committee, the Claims Committee and the Claims Administrators, 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 and the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II is the Duke Energy Investment Committee. The Chief Executive Officer of Duke Energy Corporation, or its delegate, appoints the Chairman of the Investment Committee, who in turn appoints the other members of the Investment Committee.

The Investment Committee oversees the maintenance and investment of plan assets for which it is named fiduciary, selects investment managers and collective investment funds, issues investment guidelines and objectives and monitors investment performance. The Investment Committee may be contacted through the following address:

Investment Committee
General Manager, Long Term Investments
Duke Energy Corporation
526 South Church Street, EC04Z
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:

Vice President, Legal
139 East Fourth Street - Room 25 ATII
P.O. Box 960
Cincinnati, OH 45201-0960
(513) 419-1851

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

Affiliated Employers of the Company That Have Adopted the Medical Plan

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

Claim Determination Procedures Under ERISA

The following are two different types of claims that may be made under the Medical Plan:

- claims for Medical Plan benefits; and
- 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 Medical Plan option (referred to as an "Eligibility or Enrollment Claim").

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 can also obtain additional information by calling the 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

Authority to decide an Eligibility or Enrollment Claim is assigned for initial claims to Duke Energy Human Resources, which is the Initial Claim Administrator. Human Resources has delegated its authority to the Hewitt Associates Benefits Determination Review Team. For denied claims on review, authority is assigned to the Duke Energy Claims Committee, which is the Denied Claim Reviewer.

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 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 the Benefit Determination Review Team within 90 days after the end of the plan year in which you are claiming eligibility/enrollment should have occurred.

The Benefits Determination Review Team 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 the Benefit Determination Review Team's control, it will notify you or your representative within 30 days after receiving the request. The extension notice will include 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 the Benefits Determination Review Team 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 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;
- 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 Medical Plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse determination on appeal;
- 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; and
- if the adverse determination is based on a medical necessity or experimental or investigative treatment, either a clinical or scientific explanation of the determination, applying the terms of the Medical Plan to your medical circumstances, or a statement that such clinical or scientific explanation will be provided free of charge upon request.

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.

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

Claims Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285

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. Someone other than an individual involved in the initial determination, or a subordinate of such individual, will make the determination on appeal.

You will be notified regarding the decision on your claim within 60 days. The determination of your appeal will be in writing and, if adverse, will contain the following:

- the specific reasons for the adverse determination of your appeal;
- 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 statement regarding your right to sue under Section 502(a) of ERISA following an adverse determination on your appeal 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 or investigative treatment, either a clinical or scientific explanation of the determination, applying the terms of the Medical Plan to your medical circumstances, or a statement that such clinical or scientific explanation will be provided free of charge upon request; and
- the 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."

After completing all mandatory appeal levels, you have the right to further appeal adverse determinations by bringing a civil action under ERISA. Please refer to the *Statement of ERISA Rights* section below.

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 Appeals 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 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 Denied Claim Reviewers' decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or 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.

Right to Change or Terminate the Medical Plan

Duke Energy 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 is also 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, 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 the Board of Directors, 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 insurance contracts, collective bargaining agreements and 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 insurance contracts and 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 person under 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* 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 summary plan description and the documents governing the Medical Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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 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 your 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 may also 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 myHR Service Center, if applicable, if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child marries, ceases to be a full-time student or is otherwise no longer an eligible dependent, contact the myHR Service Center as soon as possible. Certain work/life events allow you to change benefit elections that you previously made, but to do so, you must make the benefit election change within 31 calendar days of the work/life event.

A Final Note

Although this SPD describes the principal features of the Medical Plan that are generally applicable, it 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 be amended only by proper corporate action and not by oral or written communications about benefits under the Medical Plan.

Neither the Medical Plan, this SPD, nor your Medical Plan participation is an employment contract, and does 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.

Benefit Booklet

Benefit Booklet
For Participants of
Duke Energy Medical Plan
for

BlueOPTIONS℠

PPO
(Blue Card Network)

BlueCross BlueShield
of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET

This benefit booklet describes benefits provided under the Duke Energy Medical Plan's Preferred Provider Organization (PPO) option (the *Plan*). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. **Please read this benefit booklet carefully.**

The benefit plan described in this booklet is an employee health benefit plan, subject to the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Conditions, limitations and exclusions are set forth in this benefit booklet for easy reference.

In the event of a conflict between this benefit booklet and the terms in the *Plan* document, the *Plan* document will control.

BlueOPTIONS℠

Duke Energy Medical Plan

Quick Reference - Toll Free Phone Numbers, Web Site and Addresses

BCBSNC Web Site www.bcbsnc.com/members/duke-energy	To find a network provider by location or specialty, get general benefit information, search through our corporate medical policies to see medical criteria used to administer your benefits, obtain claim forms, access information about all the Blue Extras℠ discounts, "proof of coverage" portability certificates and more.
Member Services Web Site www.bcbsnc.com/members/duke-energy	To enroll in a safe and secure customer service web site to: Check claim status, verify benefits and eligibility or request a new ID card.
BCBSNC Customer Service 1-888-554-3202 8 a.m-8 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new ID card requests.
Certification 1-800-214-4844	To request certification for out-of-network inpatient services.
Magellan Behavioral Health 1-800-359-2422	For mental health and substance abuse inpatient and outpatient pre-certification. Note: You do not need certification for office visits.
Blue Card® PPO Program 1-800-810-BLUE (2583)	To find a participating provider.
Medical Claims Filing: BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
Add/Remove Someone From Your Policy	Contact Duke Energy's myHR Service Center at 1-888-465-1300

Tips for Getting the Most Out of Your Health Care Benefits

1

Manage your out-of-pocket costs by managing the locations in which you receive care

Generally speaking, care received in a doctor's office is the most cost-effective for you, followed by hospital outpatient services. Hospital inpatient services often bear the highest cost. In addition, remember that in-network care (services from a BCBSNC participating provider who agrees to charge specified rates) will cost you less than similar care provided by an out-of-network provider. Know what your financial responsibility is before receiving care.

2

Pick a primary care physician

While our products do NOT require you to have a primary care physician, we strongly urge you to select and use one. A primary care physician informs you of your health care options, documents your care, and maintains your records for you. In addition, they save you time and unnecessary copayments by recommending appropriate specialists, coordinating your care with them, and informing them of things such as your medical history and potential drug interactions.

3

Understand your health care plan

The more you know about your benefits, the easier it will be to take control of your health. Let BCBSNC help you understand your plan and use it effectively through our customer-friendly Web site (**www.bcbsnc.com/members/duke-energy**), toll free Customer Service line (1-888-554-3202).

MEMBER RIGHTS AND RESPONSIBILITIES

As a Blue Cross and Blue Shield of North Carolina member, you have the right to:

- Receive, upon request, information about Blue Options including its services, doctors, a benefit booklet, benefit summary and directory of in-network providers
- Receive courteous service from BCBSNC
- Receive considerate and respectful care from your in-network providers
- Receive the reasons for BCBSNC's denial of a requested treatment or health care service, including (upon request) an explanation of the Utilization Management criteria and treatment protocol used to reach the decision
- Receive (upon request) information on the procedure and medical criteria used by BCBSNC to determine whether a procedure, treatment, facility, equipment, drug or device is investigational, experimental or requires prior approval
- Receive accurate, reader-friendly information to help you make informed decisions about your health care
- Participate actively in all decisions related to your health care
- Discuss all treatment options candidly with your health care provider regardless of cost or benefit coverage
- Expect that measures will be taken to ensure the confidentiality of your health care information
- File a grievance and expect a fair and efficient appeals process for resolving any differences you may have with BCBSNC
- Be treated with respect and recognition of your dignity and right to privacy
- Voice complaints or appeals about the organization or the care it provides
- Make recommendations regarding the organization's members' rights and responsibilities policies

As a Blue Cross and Blue Shield of North Carolina member, you have the responsibility to:

- Present your ID card each time you receive services
- Give your doctor permission to ask for medical records from other doctors you have seen. You will be asked to sign a transfer of medical records authorization form.
- Read your Blue Options benefit booklet and all other Blue Options member materials
- Call BCBSNC Customer Services if you have a question or do not understand the material provided by BCBSNC
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, tell your doctor.
- Provide complete information about any illness, accident or health care issues to BCBSNC and providers
- Make and keep appointments for non-emergency medical care. If it is necessary to cancel an appointment, give the doctor's office adequate notice.
- Participate in understanding your health problems and the medical decisions regarding your health care
- Be considerate and courteous to Blue Options providers, their staff and BCBSNC representatives
- Notify your employer and BCBSNC if you have any other group coverage
- Notify your group administrator of any changes regarding dependents and marital status
- Protect your ID card from unauthorized use.

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WELCOME TO BLUE OPTIONS

Welcome to Blue Cross and Blue Shield of North Carolina's Blue Options plan!

As a *member* of the Blue Options plan, you will enjoy quality health care from a network of health care *providers* and easy access to *specialists*. You also have the freedom to choose health care *providers* who do not participate in the Blue Options network.

You may receive, upon request, information about Blue Options, its services and *doctors*, including this benefit booklet with a benefit summary, and a directory of *in-network providers*.

How To Use Your Blue Options Benefit Booklet

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. Please read it carefully.

If you are trying to determine whether coverage will be provided for a specific service, you may want to review all of the following:

- "Summary of Benefits" to get an overview of your specific benefits, such as *deductible*, *coinsurance* and maximum amounts
- "*Covered Services*" to get more detailed information about what is covered and what is excluded from coverage
- "*Utilization Management*" for important information about when *prior review* and *certification* are required
- "What Is Not Covered?" to see general exclusions from coverage.

If you still have questions, you can call BCBSNC Customer Services at the number listed on your *ID Card* or in "Whom Do I Call?" and get further information.

As you read this benefit booklet, keep in mind that any word you see in **italics *(italics)* is a defined term** and will appear in "Definitions" at the end of this benefit booklet.

You will also want to review the following sections of this benefit booklet:

- "How Blue Options Works" explains the coverage levels available to you
- "What If You Disagree With A Decision?" explains the rights available to you when BCBSNC makes a decision and you do not agree.

Notice For Non-English Speaking *Members*

This benefit booklet contains a summary in English of your rights and benefits under the *Plan*. If you have difficulty understanding any part of this benefit booklet, contact BCBSNC Customer Service to obtain assistance.

AVISO PARA *AFILIADOS* QUE NO HABLAN INGLES

Este manual de beneficios contiene un resumen en inglés de sus derechos y beneficios que le ofrece el *Plan*. Si usted tiene dificultad en entender alguna sección de este manual, por favor llame al BCBSNC Customer Service para recibir ayuda.

WHOM DO I CALL?

BCBSNC Web Site

To view your claims, get *Plan* information, claim forms, health and wellness information, find a *doctor,* change your address, and request new *ID cards*, visit the BCBSNC Web site: **www.bcbsnc.com/members/duke-energy**

BCBSNC Customer Service

For questions about your benefits or claims, *ID card* requests, or to voice a complaint:

BCBSNC Customer Service ..... 1-888-554-3202 (toll free)

Mental Health And Substance Abuse Services

Companies who have signed contracts with BCBSNC administer these benefits. You must contact these vendors directly and request *prior review* for *inpatient* and *outpatient* services, except for *office visit* services and in *emergencies.* In the case of an *emergency*, please notify the vendor as soon as reasonably possible:

Magellan Behavioral Health ..... 1-800-359-2422 (toll free)

HealthLine Blue SM

To receive confidential, up-to-date health information 24 hours a day from specially trained nurses:

HealthLine Blue ..... 1-877-477-2424 (toll free)

COBRA Administrator

UMR ..... 1-800-523-3578 (toll free)

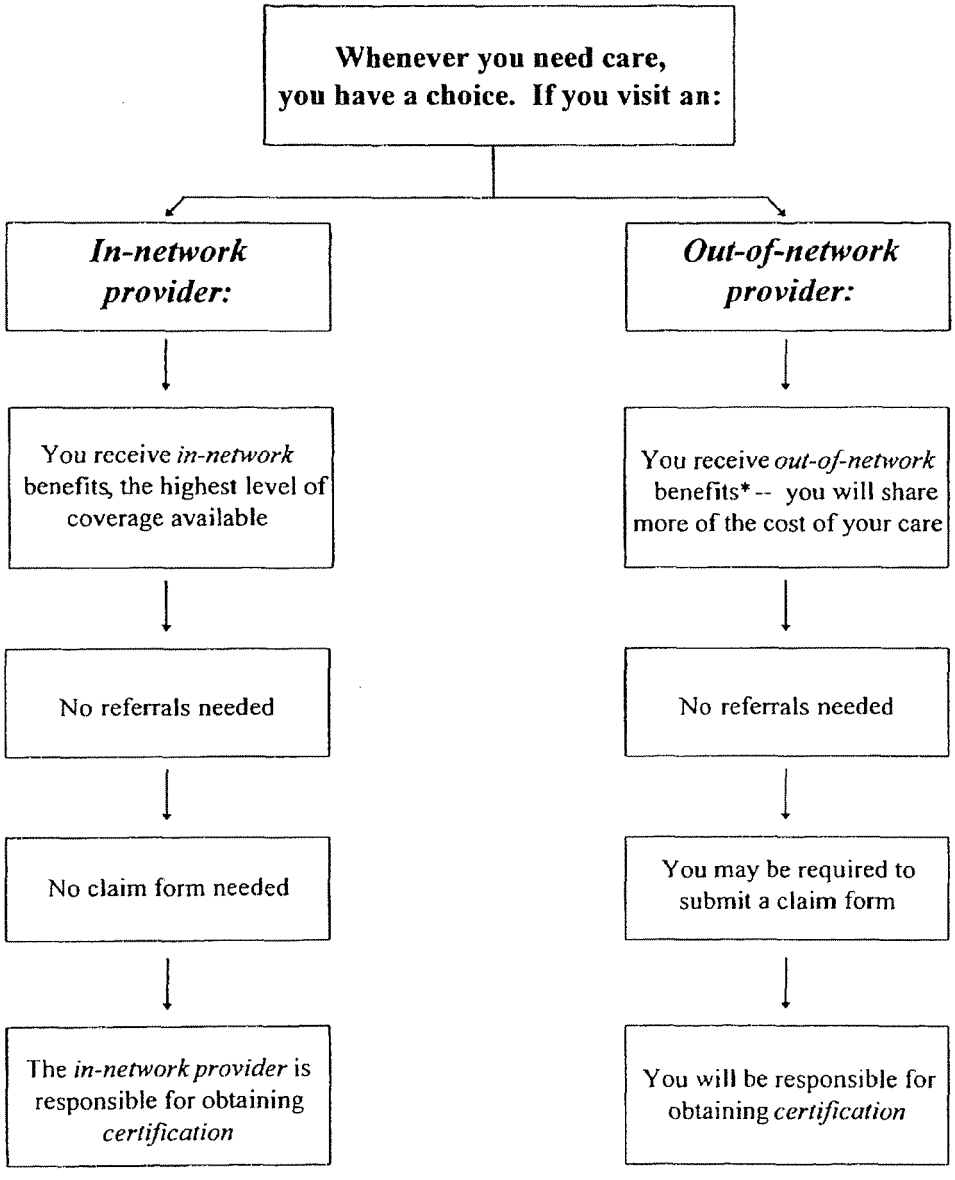
Prior Review

Some services require *prior review* and *certification* by BCBSNC. The list of these services may change from time to time. Please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed above for current information about which services require *prior review.* See "Prospective Review/*Prior Review*" in "*Utilization Management*" for information about the review process. To request *prior review,* call:

Providers ..... 1-800-214-4844 (toll free)
Members ..... 1-877-258-3334 (toll free)

HOW BLUE OPTIONS WORKS

Blue Options gives you the freedom to choose any *provider* — the main difference will be the cost to you. Here's a simple look at how it works:



* Note: Some services may not be covered *out-of-network*. Please refer to "Summary Of Benefits" and "*Covered Services*." For *out-of-network* benefits, you may be required to pay charges over the *allowed amount*, in addition to your *out-of-network deductible* and *coinsurance* amount. In an *emergency*, in situations where *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, or in continuity of care situations, *out-of-network* benefits will be paid at your *in-network coinsurance* and will be based on the billed amount. However, you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement. If you are billed by the *provider*, you will be responsible for paying the bill and filing a claim with BCBSNC. For more information, see "*Emergency* Care," "Continuity Of Care" in "*Utilization Management*," and for information about BCBSNC's access to care standards, see the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy.** If you believe an *in-network provider* is not reasonably available, you can

help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an *out-of-network provider*.

In-Network Benefits

In-network providers are health care professionals and facilities that have contracted with BCBSNC, or *providers* participating in the BlueCard PPO program. *In-network providers* agree to limit charges for *covered services* to the *allowed amount*. If the billed amount is greater than the *allowed amount*, you are not responsible for the difference. You pay only the applicable *copayment* or *coinsurance*, and noncovered expenses. Your *in-network provider* is required to use the Blue Options network *hospital* where he/she practices, unless that *hospital* cannot provide the services you need.

Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the BlueCard PPO program. Your *ID card* tells participating *providers* that you are a member of BCBSNC. When you use a *provider* participating in the local Blue Cross or Blue Shield Plan's *provider* network, benefits are provided at the *in-network copayment* or *coinsurance*.

You are not required to obtain any referrals to see an *in-network provider*. *In-network providers* will file claims for you. It is the *member's* responsibility to request *prior review* when necessary. *Prior review* is not required for an *emergency*.

The list of *in-network providers* may change from time to time. *In-network providers* are listed on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" Please note that *dentists* and orthodontists do not participate in the *provider* network.

Out-Of-Network Benefits

With the Blue Options plan, you may choose to receive *covered services* from an *out-of-network provider - providers* not designated as a Blue Options provider by BCBSNC. When you see an *out-of-network provider*, you may be responsible for paying any charges over the *allowed amount* in addition to your *copayments* or *coinsurance*, noncovered expenses and *certification* penalty, if any. BCBSNC encourages you to discuss the cost of services with *out-of-network providers* before receiving care so you will be aware of your total financial responsibility.

You are not required to obtain any referrals to see an *out-of-network provider*. You may have to pay the *out-of-network provider* in full and submit a claim form to BCBSNC if the *out-of-network provider* does not bill BCBSNC directly for services.

Out-of-network providers, unlike *in-network providers*, are not obligated by contract to request *prior review* by BCBSNC. If you go to an *out-of-network provider* or receive care outside of North Carolina, it is your responsibility to request or ensure that your *provider* requests *prior review* by BCBSNC. Failure to request *prior review* and obtain *certification* may result in a partial or full denial of benefits. Before receiving the service, you may want to verify with BCBSNC that *certification* has been obtained. See "Prospective Review/*Prior Review*" in "*Utilization Management*" for additional information. *Prior review* is not required for an *emergency*.

Out-Of-Network Benefit Exceptions

In an *emergency*, in situations where *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, or in continuity of care situations, *out-of-network* benefits will be paid at your *in-network copayment* or *coinsurance* and will be based on the billed amount. However, you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement. If you are billed by the *provider*, you will be responsible for paying the bill and filing a claim with BCBSNC.

For more information, see "*Emergency* Care," "Continuity Of Care" in "*Utilization Management*," and for information about BCBSNC's access to care standards, see the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy**. If you believe an *in-network provider* is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an *out-of-network provider*.

The Role Of A *Primary Care Provider (PCP)* Or *Specialist*

It is important for you to maintain a relationship with a *PCP*, who will help you manage your health and help you make decisions about your health care. If you change *PCPs*, be sure to have your medical records transferred, especially immunization records, to provide your new *doctor* with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care *provider* regardless of cost or benefit coverage. *PCPs* are trained to deal with a broad range of health care issues and can help you to determine when you need a *specialist*.

Please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service to be sure the *provider* you choose is available to be a *PCP*. You may want to confirm that the *provider* is in the network before receiving care.

If your *PCP* or *specialist* leaves the BCBSNC *provider* network and they are currently treating you for an ongoing special condition, see "Continuity Of Care" in "*Utilization Management.*"

Members with serious or chronic disabling or life-threatening conditions may be allowed to select the *specialist* treating this condition as their *PCP*. The selected *specialist* would be responsible for providing and coordinating the *member's* primary and specialty care. The selection of a *specialist* under these circumstances shall be made under a treatment plan approved by the *specialist*, and BCBSNC, with notice to the *PCP* if applicable. A request may be denied where it is determined that the *specialist* cannot appropriately coordinate the *member's* primary and specialty care. To make this request or if you would like the professional qualifications of your *PCP* or *in-network specialist*, you may call BCBSNC Customer Service at the number given in "Whom Do I Call?"

Carry Your *Identification Card*

Your *ID card* identifies you as a Blue Options *member*. If any information on your *ID card* is incorrect or if you need additional cards, please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" **Be sure to carry your *ID card* with you at all times and present it each time you seek health care.**

Making An Appointment

Call the *provider's* office and identify yourself as a Blue Options *member*. Please ask the receptionist whether the *provider's* office is *hospital*-owned or operated or provides *hospital*-based services. Your *medical services* may be covered under *Outpatient* Services benefit. Your *provider* directory will also help you make this determination. *Provider* directories are available through the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or by calling BCBSNC Customer Service at the number given in "Whom Do I Call?" If you need nonemergency services after your *provider's* office has closed, please call your *provider's* office for their recorded instructions. You may also contact the nurse advice line, HealthLine Blue, for assistance.

If you cannot keep an appointment, call the *provider's* office as soon as possible. Charges for missed appointments, which *providers* may require as part of their routine practice, are not covered.

HealthLine Blue

You may call a HealthLine Blue nurse to assist you with medical questions, offer support, and send you free videotapes and brochures on health topics appropriate for your condition. *Members* may ask to speak with the same nurse on an ongoing basis. You may also visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** to search a library of current health topics, send secure messages to the HealthLine Blue nurses, learn about symptoms and medications and use tools that guide you through important health care decisions. See the number listed in "Whom Do I Call?" to speak to a HealthLine Blue nurse.

How To File A Claim

When you file a claim, mail the completed claim form for all *medical services*, including mental health and substance abuse services, to:

BCBSNC
Claims Department
PO Box 35
Durham, NC 27702-0035

Mail claims in time to be received within 15 months of the date the service was provided. Claims not received within 15 months from the service date will not be covered, except in the absence of legal capacity of the *member*.

You may obtain a claim form, including international claim forms, by visiting the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or calling BCBSNC Customer Service at the number listed in "Whom Do I Call?" For help filing a claim, call BCBSNC Customer Service or write to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

COVERED SERVICES

Blue Options covers only those services that are *medically necessary*. Also keep in mind as you read this section:

- **Certain services require *prior review* and *certification* in order for you to avoid a partial (penalty) or complete denial of benefits. General categories of services are noted below as requiring *prior review*. Also see "Prospective Review/*Prior Review*" in "*Utilization Management*" for information about the review process, and visit the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or call BCBSNC Customer Service to ask whether a specific service requires *prior review* and *certification*.**
- Exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "*Covered Services*." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "*Covered Services*" and "What Is Not Covered?"
- You may also receive, upon request, information on the procedure and medical criteria used by BCBSNC to determine whether a procedure, treatment, facility, equipment, drug or device is *medically necessary* and eligible for coverage, *investigational* or *experimental*, or requires *prior review* and *certification* by BCBSNC. **BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. If you need more information about our medical policies, see the BCBSNC Web site at www.bcbsnc.com/members/duke-energy, or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"**

Office Services

Care you receive as part of an *office visit* or house call is covered with a *copayment*, except as otherwise noted in this benefit booklet. Some *providers* may receive items such as supplies or drugs from third parties. In these cases, you may be billed directly by the supplier. Benefit payments for these services will be based on the type of supplier and how the services are billed.

The *Plan* also provides benefits for six nutritional visits per *benefit period*. Your benefits cover a total of six visits to an in- or *out-of-network provider*. If you see an *in-network provider*, any applicable *copayment, coinsurance* or *deductible* is waived for these six visits. If you go to an *out-of-network provider, deductible* and *coinsurance* will apply.

A *copayment* will not apply if you only receive services, such as allergy shots or other injections, and are not charged for an *office visit*.

Certain diagnostic imaging procedures, such as CT scans and MRIs, are subject to *coinsurance* and any applicable *deductible*, and may require *prior review* and *certification* or services will not be covered.

Some *doctors* or *other providers* may practice in *outpatient clinics* or provide *hospital*-based services in their offices. These services are covered as *Outpatient* Services and are listed as *Outpatient Clinic* Services in "Summary Of Benefits." The *provider* search on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** indicates which *providers* will collect *deductible* and *coinsurance*, or you can call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for this information.

Office Services Exclusion

- Services in free-standing surgical facilities, independent laboratories, therapy facilities or *outpatient hospital* departments.

Preventive Care

The *Plan* covers *preventive care* services that can help you stay safe and healthy.

Routine Physical Examinations

One routine physical examination and related diagnostic services per *benefit period* will be covered for each *member* age two and older.

Well-Baby And Well-Child Care

These services are covered for each *member* up to 24 months of age including periodic assessments and immunizations. Benefits are limited to six well-baby visits for *members* through 12 months old and three well-child visits for *members* 13 months to 24 months old.

Immunizations

The full series of standard immunizations recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians (AAFP) is covered.

Covered immunizations include the following:

- Tetanus, diphtheria, pertussis (Td/Tdap)
- Polio
- HiB
- Hepatitis A and B

- Measles-Mumps-Rubella (MMR)
- Influenza
- Pneumococcal vaccine
- Shingles
- Meningococcal vaccine (available in- and *out-of-network*).
- Human papillomavirus vaccine
- Chicken pox
- Rotavirus

Immunizations Exclusions

- Immunizations required for occupational hazard
- Immunizations required for international travel.

See "Summary Of Benefits" for the following services, since benefits may vary depending on where services are received.

The following benefits are available *in-network* and *out-of-network*:

Gynecological Exam And Cervical Cancer Screening

The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and *doctor's* interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papilloma virus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

Ovarian Cancer Screening

For female *members* age 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered. A female *member* is considered "at risk" if she:

- Has a family history with at least one first-degree relative with ovarian cancer; and a second relative, either first-degree or second-degree with breast, ovarian, or nonpolyposis colorectal cancer; or
- Tested positive for a hereditary ovarian cancer syndrome.

Screening Mammograms

Beginning at age 35, one screening mammogram will be covered per female *member* per calendar year, along with a *doctor's* interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a *doctor* when a female *member* is considered at risk for breast cancer.

A female *member* is "at risk" if she:

- Has a personal history of breast cancer
- Has a personal history of biopsy-proven benign breast disease
- Has a mother, sister, or daughter who has or has had breast cancer, or
- Has not given birth before the age of 30.

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic *member* who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer. Increased/high risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered *surgery,* such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as Hemoccult screenings.

The *provider* search on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** can help you find office-based *providers* or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for this information.

Prostate Screening

One prostate specific antigen (PSA) test or an equivalent serological test will be covered per male *member* per calendar year. Additional PSA tests will be covered if recommended by a *doctor*.

Diagnostic Services

Diagnostic procedures such as laboratory studies, radiology services and other diagnostic testing, which may include electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs), help your *doctor* find the cause and extent of your condition in order to plan for your care.

Certain diagnostic imaging procedures, such as CT scans and MRIs, may require *prior review* and *certification* or services will not be covered.

Your *doctor* may refer you to a freestanding radiology center for these procedures. Separate benefits for interpretation of diagnostic services by the attending *doctor* are not provided in addition to benefits for that *doctor's* medical or surgical services, except as otherwise determined by BCBSNC.

Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure. See "Summary Of Benefits."

Bone Mass Measurement Services

The *Plan* covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if *medically necessary*. Qualified individuals include *members* who have any one of the following conditions:

- Estrogen-deficient and at clinical risk of osteoporosis or low bone mass
- Radiographic osteopenia anywhere in the skeleton
- Receiving long-term glucocorticoid (steroid) therapy
- Primary hyperparathyroidism
- Being monitored to assess the response or effect of commonly accepted osteoporosis drug therapies
- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

See *Outpatient* Services in the "Summary Of Benefits."

Emergency Care

The *Plan* provides benefits for *emergency services*. An *emergency* is the sudden and unexpected onset of a condition of such severity 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 an individual, or with respect to a pregnant woman the health of the pregnant woman or her unborn child, in serious jeopardy
- Serious physical impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Death.

Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of *emergencies*.

What To Do In An *Emergency*

In an *emergency*, you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community emergency resources to obtain assistance in handling life-threatening *emergencies*. If you are unsure if your condition is an *emergency*, you can call HealthLine Blue; and a HealthLine Blue nurse will provide information and support that may save you an unnecessary trip to the emergency room.

Prior review is not required for *emergency services*. Your visit to the emergency room will be covered if your condition meets the definition of an *emergency*.

If you go to an emergency room for treatment of an *emergency*, your *coinsurance* will be the same, whether you use an *in-network* or *out-of-network provider*. When you receive these services from an *out-of-network provider*, benefits are based on the billed amount. However you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement, and you may be required to pay the entire bill at the time of service, and file a claim with BCBSNC.

Prior review and *certification* by BCBSNC are required for *inpatient* hospitalization and other selected services following *emergency services* (including screening and stabilization) in order to avoid a penalty. You may need to transfer to an *in-network hospital* once your condition has been *stabilized* in order to continue receiving *in-network* benefits.

Care Following *Emergency Services*

In order to receive *in-network* benefits for follow-up care related to the *emergency* (such as *office visits* or therapy once you left the emergency room or were discharged from the *hospital*), you must use *in-network providers*. Follow-up care related to the *emergency* condition is not considered an *emergency* and will be treated the same as a normal health care benefit.

Urgent Care

The *Plan* also provides benefits for *urgent care* services. When you need *urgent care,* call your *PCP,* a *specialist* or go to an *urgent care provider.* If you are not sure if your condition requires *urgent care,* you can call HealthLine Blue.

Urgent care includes services provided for a condition that occurs suddenly and unexpectedly and requires prompt diagnosis or treatment such that, in the absence of immediate care, the *member* could reasonably be expected to suffer chronic illness, prolonged impairment or the need for more serious treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female *members.* A *copayment* may apply for the *office visit* to diagnose pregnancy. If a *member* changes *providers* during pregnancy, terminates coverage during pregnancy, or the pregnancy does not result in delivery, one or more *copayments* may be charged for pre-natal services depending upon how the services are billed by the *provider.*

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 *doctor,* nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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.*

If the mother chooses a shorter stay, coverage is available for a *home health* visit for post-delivery follow-up care if received within 72 hours of discharge. In order to avoid a penalty, *prior review* and *certification* are required for *inpatient* stays extending beyond 48 hours following a vaginal delivery or 96 hours following a cesarean section. For information on *certification,* contact BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Termination of Pregnancy (Therapeutic Abortion)

Benefits for therapeutic abortion are available through the first 16 weeks of pregnancy for all female *members.*

Complications Of Pregnancy

Benefits for *complications of pregnancy* are available to all female *members* including dependent children. Please see "Definitions" for an explanation of *complications of pregnancy.*

Newborn Care

Inpatient newborn care of a well baby is covered under the mother's maternity benefits described above only during the first 48 hours after a vaginal delivery or 96 hours after delivery by cesarean section. This *inpatient* newborn care (well baby) requires only one *benefit period deductible* for both mother and baby. Benefits also include newborn hearing screening ordered by a *doctor* to determine the presence of permanent hearing loss.

For additional coverage of the newborn, whether *inpatient* (sick baby) or *outpatient,* the newborn must be enrolled for coverage as a dependent child within 31 days of the birth. At this time, the baby must meet the individual *benefit period deductible* if applicable, and *prior review* and *certification* are required to avoid a penalty.

Infertility And *Sexual Dysfunction* Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of *infertility* and *sexual dysfunction* for all *members* except dependent children.

Sterilization

This benefit is available for all *members* except dependent children. Sterilization includes female tubal ligation and male vasectomy.

Family Planning Exclusions

- The collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
- Artificial means of conception, including, but not limited to, artificial insemination, in-vitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm insemination (ICSI), and gamete intrafallopian tube placement (GIFT) and associated services
- Donor eggs and sperm
- Surrogate mothers
- Care or treatment of the following:
  - termination of pregnancy
  - contraceptive devices
  - reversal of sterilization
  - *infertility* and *sexual dysfunction* for dependent children.
- Elective abortion
- Treatment for *infertility* or reduced fertility that results from a prior sterilization procedure or when *infertility* or reduced fertility is the result of a normal physiological change such as menopause.

Facility Services

- *Outpatient* services received in a *hospital*, a *hospital*-based facility or an *outpatient clinic*.
- *Inpatient hospital* services. If you are admitted before the *effective date*, benefits will not be available for services received prior to the *effective date*. *Prior review* must be requested and *certification* must be obtained in advance from BCBSNC to avoid a penalty, except for maternity deliveries and *emergencies*. See "Maternity Care" and "*Emergency* Care."
- Surgical services received in an *ambulatory surgical center*
- *Covered services* received in a *skilled nursing facility*. *Prior review* must be requested and *certification* must be obtained in advance from BCBSNC to avoid a penalty. *Skilled nursing facility* services are limited to a combined *in-network* and *out-of-network* day maximum per *benefit period*. See "Summary Of Benefits."

Other Services

Ambulance Services

The *Plan* covers services in a ground *ambulance* traveling:

- From a *member's* home or scene of an accident or *emergency* to a *hospital*
- Between *hospitals*
- Between a *hospital* and a *skilled nursing facility*

when such a facility is the closest one that can provide *covered services* appropriate to your condition. Benefits may also be provided for *ambulance* services from a *hospital* or *skilled nursing facility* to a *member's* home when *medically necessary*.

The *Plan* covers services in an air *ambulance* traveling from the site of an *emergency* to a *hospital* when such a facility is the closest one that can provide *covered services* appropriate to your condition and ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land. Nonemergency air *ambulance* services require *prior review* and *certification* or services will not be covered.

Ambulance Service Exclusion

- No benefits are provided primarily for the convenience of travel.

Blood

The *Plan* covers the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a *member's* own blood only when it is stored and used for a previously scheduled procedure.

Blood Exclusion

- Charges for the collection or obtainment of blood or blood products from a blood donor, including the *member* in the case of autologous blood donation.

Clinical Trials

The *Plan* provides benefits for participation in clinical trials phases II, III, and IV. Coverage is provided only for *medically necessary* costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The *member* must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of a life-threatening medical condition with services that are medically indicated and preferable for that *member* compared to non-*investigational* alternatives. In addition, the trial must:

- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical specialists
- Be approved by centers or groups funded by the National Institutes of Health, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

Clinical Trials Exclusions

- Clinical trials phase I
- Non-health care services, such as services provided for data collection and analysis
- *Investigational* drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

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:

- Accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- *Congenital* deformity, including cleft lip and cleft palate
- Disease due to infection or tumor, including tumors, cysts and exostosis
- Temporomandibular joint (TMJ) disease, including splinting and use of intra-oral *prosthetic appliances* to reposition the bones. Surgical benefits for TMJ disease are limited to *surgery* performed on the temporomandibular joint. If TMJ is caused by malocclusion, then benefits are provided for surgical correction of malocclusion if surgical management of the TMJ is *medically necessary*. Please have your *provider* contact BCBSNC before receiving treatment for TMJ.
- Impacted wisdom teeth.

The *Plan* provides benefits for extractions, crowns, bridges, and dentures for treatment of disease due to infection or tumor. For treatment of *congenital* deformity including cleft lip and cleft palate, benefits may be provided for dentures and orthodontic braces used to treat the condition.

When any of the conditions listed above require surgical correction, benefits for *surgery* will be subject to *medical necessity* 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*. *Prior review* and *certification* are required or services will not be covered, unless treatment is for an *emergency*.

Dental Treatment Excluded Under Your Medical Benefit

- Injury related to chewing or biting
- Preventive dental care, diagnosis or treatment of or related to the teeth or gums
- For disease due to infection or tumor:
  - Dental implants
  - Treatment for periodontal disease
  - Dental root form implants or root canals
  - Orthodontic braces

COVERED SERVICES (cont.)

- For TMJ disease:
  - Dental implants
  - Treatment for periodontal disease
  - Dental root form implants or root canals
  - Crowns and bridges
  - Extractions
  - Dentures
  - Orthodontic braces
- Replacement of crowns, bridges, dentures or in-mouth appliances, except as specifically stated as covered.

Durable Medical Equipment

Benefits are provided for *durable medical equipment* and supplies required for operation of equipment when prescribed by a *doctor*. Equipment may be purchased or rented at the discretion of the *Plan*. The *Plan* provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer *medically necessary*. Certain *durable medical equipment* requires *prior review* and *certification* or services will not be covered.

Durable Medical Equipment Exclusions

- Appliances that serve no medical purpose or that are primarily for comfort or convenience
- Repair or replacement of equipment due to abuse or desire for new equipment
- Rental or purchase of wheelchairs, hospital type beds, oxygen equipment (including oxygen), insulin pumps, Glucowatch and Autosensors, nebulizers and supplies related to the use of nebulizers and other *durable medical equipment*, subject to the following:
  - The equipment must be prescribed by a physician and needed in the treatment of an illness or injury and will be provided on a rental basis for the period of treatment. At our option, such equipment may be purchased. If the equipment is purchased, benefits will be payable for subsequent repairs necessary to restore the equipment to a serviceable condition; subsequent repairs due to abuse or misuse, as determined by BCBSNC, are not covered;
  - Benefits will be limited to the standard models, as determined by BCBSNC;
  - The *Plan* will pay benefits, if determined to be *medically necessary*, for ONE of the following: a manual wheelchair, a motorized wheelchair, or motorized scooter.

BCBSNC will pay benefits for the replacement of any *durable medical equipment* subject to the proof of change in a medical condition or that the equipment is no longer usable or repairable.

Eye Exams

The *Plan* provides coverage for one routine comprehensive eye examination per *benefit period*. Diagnosis and treatment of medical conditions of the eye, and drugs administered for purposes other than for a visual examination, are not considered to be part of a routine eye exam and are subject to the benefits, limitations and exclusions of the *Plan*.

Eye Exams Exclusion

- Fitting for contact lenses, glasses or other hardware.

Home Health Care

Home health care services, such as professional services of a *registered nurse (RN)* or *licensed practical nurse (LPN)* for visits totaling 8 hours a day, are covered by the *Plan* when the *member* is *homebound* due to illness or injury. *Home health* care requires *prior review* and *certification* or services will not be covered.

Home Health Care Exclusions

- Homemaker services, such as cooking and housekeeping
- Dietitian services or meals
- Services that are provided by a close relative or a member of your household.

Home Infusion Therapy Services

Home infusion therapy is covered for the administration of *prescription drugs* directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a *doctor*. These services must be provided under the supervision of an *RN* or *LPN*. Home infusion therapy requires *prior review* and *certification* or services will not be covered.

Hospice Services

- Your coverage provides benefits for *hospice* services for care of a terminally ill *member* with a life expectancy of six months or less. Services are covered only as part of a licensed health care program centrally coordinated through an interdisciplinary team directed by a *doctor* that provides an integrated set of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families.

Hospice Services Exclusion

- Homemaker services, such as cooking, housekeeping, food or meals.

Medical Supplies

Coverage is provided for *medical supplies* such as ostomy supplies, catheters, oxygen and diabetic pump and pump supplies (needles, syringes, teststrips are covered under the pharmacy plan). To obtain *medical supplies*/equipment, please find a *provider* on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service.

Medical Supplies Exclusion

- *Medical supplies* not ordered by a *doctor* for treatment of a specific diagnosis or procedure.

Orthotic Devices

Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part, are covered if *medically necessary* and prescribed by a *provider*. Foot orthotics may be covered only when custom molded to the patient. Charges for custom built orthopedic shoes when *medically necessary* must be prescribed by a *doctor* and limited to two (2) pairs per calendar year. Orthotic devices for correction of *positional plagiocephaly*, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, are subject to a benefit limit.

Orthotic Devices Exclusions

- Pre-molded foot orthotics
- Over-the-counter supportive devices.

Private Duty Nursing

The *Plan* provides benefits for *medically necessary* private duty services of an *RN* or *LPN* when ordered by your *doctor*. *Prior review* must be requested and *certification* must be obtained or services will not be covered. These services are always subject to the *deductible* and *coinsurance*, regardless of location of service.

Private Duty Nursing Exclusion

- Services provided by a close relative or a member of your household.

Prosthetic Appliances

The *Plan* provides benefits for the purchase, fitting, adjustments, repairs, and replacement of *prosthetic appliances*. The *prosthetic appliances* must replace all or part of a body part or its function. The type of *prosthetic appliance* will be based on the functional level of the *member*. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a prescription change after cataract *surgery*. Certain *prosthetic appliances* require *prior review* and *certification* or services will not be covered.

Prosthetic Appliances Exclusions

- Dental appliances except when *medically necessary* for the treatment of temporomandibular joint disease
- *Cosmetic* improvements, such as implantation of hair follicles and skin tone enhancements
- Lenses for keratoconus or any other eye procedure except as specifically covered under the *Plan*.

Surgical Benefits

Surgical benefits by a professional or facility *provider* on an *inpatient* or *outpatient* basis, including pre-operative and post-operative care and care of complications, are covered. Surgical benefits include diagnostic *surgery*, such as biopsies, sigmoidoscopies and colonoscopies, and reconstructive *surgery* performed to correct *congenital* defects that result in functional impairment of newborn, adoptive and foster children.

Certain surgical procedures, including those that are potentially *cosmetic*, require *prior review* and *certification* or services will not be covered.

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter, may not be eligible for separate reimbursement. For information about coverage of multiple surgical procedures, please

refer to BCBSNC's medical policies, which are on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy**, or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Anesthesia

Your anesthesia benefit includes coverage for general, spinal block or monitored regional anesthesia ordered by the attending *doctor* and administered by or under the supervision of a *doctor* other than the attending surgeon or assistant at *surgery*. Separate benefits are not available for related services. Your coverage does not provide additional benefits for local anesthetics, which are covered as part of your surgical benefit.

Mastectomy Benefits

Under the Women's Health and Cancer Rights Act of 1998, the *Plan* provides for the following services related to mastectomy *surgery*:

- Reconstruction of the breast on which the mastectomy has been performed
- *Surgery* and reconstruction of the nondiseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive *surgery*
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Please note that the decision to discharge the patient following mastectomy *surgery* is made by the attending physician in consultation with the patient.

The benefits described above are subject to the same *deductibles, copayment* or *coinsurance* and limitations as applied to other medical and surgical benefits provided under the *Plan*.

Therapies

The *Plan* provides coverage for the following therapy services to promote the recovery of a *member* from an illness, disease or injury. A *doctor* or *other professional provider* must order these services.

Short-Term Rehabilitative Therapies

The following therapies are covered only for treatment of conditions that are expected to result in significant clinical improvement in a *member's* condition:

- Occupational therapy and/or physical therapy
- Speech therapy.

Benefits are limited to a combined *in-network* and *out-of-network benefit period* visit maximum for the following categories of therapies: occupational and/or physical therapy, speech therapy, chiropractic services or any combination of these therapies. These visit limits apply in all places of service except *inpatient* (e.g., *outpatient*, office and home) regardless of the type of *provider* (chiropractors, other *doctors*, physical therapists). *Short-term rehabilitative therapy* received while an *inpatient* is not included in the *benefit period maximum*.

Other Therapies

The *Plan* covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Chemotherapy, including intravenous chemotherapy. For bone marrow or peripheral blood stem cell *transplants*, see "*Transplants*."

- Radiation therapy (including accelerated partial breast radiotherapy (breast brachytherapy). Breast brachytherapy is *investigational* but will be covered upon *prior review* and *certification*, based on meeting the American Society of Breast Surgeons (ASBS) criteria.)
- Limited treatment of autism, consisting of:

(A) Therapy to develop interactive skills and skills necessary to perform the significant activities of daily living (eating, dressing, walking, bathing, toileting, and communicating). (The therapy must be performed by a licensed medical provider approved in advance. This therapy is not intended for schooling of an individual, even if the schooling requires a special environment. The provider must submit a treatment plan including the type of therapy to be administered, the goals, setting and periodic measures for the therapy, who will administer the therapy, and the patient's current ability to perform the desired results of the therapy. The treatment plan must be approved in advance by the Claims Administrator and updated quarterly with a report on the patient's condition, progress and future treatment plans.)

(B) Care provided in accordance with the approved treatment plan by a non-licensed medical provider who is not a member of the patient's family, if the provider has been specifically trained to interact with the autistic patient and certified by a licensed medical provider as capable of working with the child. (This benefit is payable up to $50,000 during the lifetime of the patient, for the specific diagnosis of autism.)

(C) Training and educational services provided by licensed medical providers (or non-licensed providers as described above) under an approved treatment plan for the parents or legal guardian of an autistic individual to teach the principles and practical applications of behavior modification (This benefit is payable up to $5,000 during the lifetime of the patient.)

Therapy Exclusions

- Cognitive therapy
- Speech therapy for stammering or stuttering.

Transplants

The *Plan* provides benefits for *transplants*, including *hospital* and professional services for covered *transplant* procedures. The *Plan* provides care management for *transplant* services and will help you find a *hospital* or Blue Quality Center for Transplants that provides the *transplant* services required. Travel and lodging expenses may be reimbursed, based on BCBSNC guidelines that are available upon request from a *transplant* coordinator.

For a list of covered transplants, call BCBSNC Customer Service at the number listed in "Whom Do I Call?" to speak with a *transplant* coordinator and request *prior review*. *Certification* must be obtained in advance from BCBSNC for all *transplant*-related services in order to assure coverage of these services.

If a *transplant* is provided from a living donor to the recipient *member* who will receive the *transplant*:

- Benefits are provided for reasonable and necessary services related to the search for a donor up to a maximum of $10,000 per *transplant*. However, other costs related to evaluation and procurement are covered up to the recipient *member's* coverage limit.
- Both the recipient and the donor are entitled to benefits of this coverage when the recipient is a *member*. Benefits provided to the donor will be charged against the recipient's coverage, if they don't have coverage for same elsewhere.

Some *transplant* services are *investigational* and not covered for some or all conditions or illnesses. Please see "Definitions" for an explanation of *investigational*.

Transplants Exclusions

- The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient *member*
- The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a *member*
- *Transplants*, including high dose chemotherapy, considered *experimental* or *investigational*
- Services for or related to the transplantation of animal or artificial organs or tissues.

Mental Health And Substance Abuse Services

The *Plan* provides benefits for the treatment by a of *mental illness* and substance abuse by a *hospital, doctor* or *other provider*. Your coverage for *in-network inpatient* and *outpatient* services is coordinated through Magellan Behavioral Health.

Separate visit limits and benefit maximums may apply and are combined for in- and *out-of-network* services. See information on *office visit* benefit maximums below.

Office Visit Services

Prior review by Magellan Behavioral Health is not required for *office visit* services. The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- *Medically necessary* biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

The following rules apply to mental health *office visit* benefit maximums:

- Each service provided by a mental health *provider* will count as one visit
- Any mental health therapy services provided by a non-mental health *provider* during the course of an *office visit* will count as one visit.

Outpatient Services

Covered *outpatient* services when provided in a mental health or substance abuse treatment facility include:

- Each service listed in this section under *office visit* services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).

Inpatient Services

Covered *inpatient* treatment services also include:

- Each service listed in this section under *office visit* services
- Semi-private room and board
- Detoxification to treat substance abuse.

Please note benefits for *inpatient* and *outpatient medical care* are limited to one visit per day.

How To Access Mental Health And Substance Abuse Services

Prior review by Magellan Behavioral Health is not required for *office visit* services, or for services from an *out-of-network provider* which will be paid at the *out-of-network* benefit level. Although *prior review* is not required for *emergency* situations, please notify Magellan Behavioral Health of your *inpatient* admission as soon as reasonably possible. In addition, if you choose to receive nonemergency *inpatient* or *outpatient* services from an *in-network provider* without requesting *prior review* and receiving *certification* from Magellan Behavioral Health, you will receive coverage at the *out-of-network* benefit level and will be responsible for the difference between the *allowed amount* and the *provider's* full charge.

When you need *inpatient* or *outpatient* treatment, call a Magellan Behavioral Health customer service representative at the number listed in "Whom Do I Call?" The Magellan Behavioral Health customer service representative will refer you to an appropriate *in-network provider* and give you information about *prior review* and *certification* requirements.

Mental Health And Substance Abuse Services Exclusions And Limitations

- Psychoanalysis
- Counseling with relatives about a patient with *mental illness*, alcoholism, drug addiction or chemical dependency
- *Inpatient* confinements that are primarily intended as a change of environment
- Mental health services received in residential treatment facilities
- Mental health *covered services* are subject to the medical *deductible* and apply toward the medical *coinsurance maximum*
- Substance abuse *covered services* are subject to the medical *deductible* and do not apply toward the medical *coinsurance maximum*.

WHAT IS NOT COVERED?

Exclusions for a specific type of service are stated along with the benefit description in "*Covered Services.*" Exclusions that apply to many services are listed in this section. To understand all of the exclusions that apply, read "*Covered Services*," "Summary Of Benefits" and "What Is Not Covered?" In addition, the *Plan* does not cover services, supplies, drugs or charges for:

- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under the *Plan*
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- A dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group
- Dates of service received prior to the *member's effective da*te
- A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet.

A

Acupuncture and acupressure, unless services are provided by a medical *doctor*

Administrative charges billed by a *provider*, including charges for telephone consultations, failure to keep a scheduled visit, completion of claim forms, obtaining medical records, and late payments

Costs in excess of the ***allowed amount*** for services usually provided by one *doctor*, when those services are provided by multiple *doctors* or *medical care* provided by more than one *doctor* for treatment of the same condition

C

Claims not submitted to BCBSNC within 18 months of the date the charge was *incurred*, except in the absence of legal capacity of the *member*

Contraceptives, including oral and injectable contraceptives, contraceptive devices and long-term reversible contraceptives including, but not limited to, intrauterine devices and implanted hormonal contraceptives, solely prescribed for the purpose of contraception. These services are excluded at the request of your *employer*.

Convenience items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items

Cosmetic services, which include removal of excess skin from the abdomen, arms or thighs, and *surgery* for psychological or emotional reasons, except as specifically covered by the *Plan*

Services received either before or after the **coverage period** of the *Plan*, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination

Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*.

D

Dental services provided in a *hospital*, except as specifically covered by the *Plan*, when a hazardous condition exists at the same time, or covered oral *surgery* services are required at the same time as a result of a bodily injury. Dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by the *Plan*.

The following **drugs:**

- *Prescription drugs* except as specifically covered by the *Plan*
- Injections by a health care professional of injectable *prescription drugs* which can be self-administered, unless medical supervision is required
- Clomiphene (e.g., Clomid), menotropins (e.g., Repronex) or other drugs associated with conception by artificial means
- *Experimental* drugs or any drug not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to *prescription drugs* used in covered phases II,

WHAT IS NOT COVERED? *(cont.)*

III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been approved as effective in any one of the three nationally recognized drug reference guides:

1. The American Medical Association Drug Evaluations
2. The American Hospital Formulary Service Drug Information
3. The United States Pharmacopoeia Drug Information.

E

Services primarily for **educational** purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by the *Plan*

Side effects and complications of noncovered services, except for *emergency services* in the case of an ***emergency***

Services that would not be necessary if a noncovered service had not been received, except for *emergency services* in the case of an ***emergency***

The following **equipment**:

- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, pool or memberships to health clubs.

Experimental services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service, except as specifically covered by the *Plan*

F

*Routine **foot care*** that is palliative or *cosmetic*

G

Genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing

H

Hearing aids or examinations for the fitting of hearing aids except as specifically covered by the *Plan*

***Holistic** medicine* services

Hypnosis except when used for control of acute or chronic pain

I

Inpatient **admissions** primarily for the purpose of receiving diagnostic services or a physical examination. *Inpatient* admissions primarily for the purpose of receiving therapy services, except when the admission is a continuation of treatment following care at an *inpatient* facility for an illness or accident requiring therapy.

Investigational services in nature or obsolete, including any service, drugs, procedure or treatment directly related to an *investigational* treatment, except as specifically covered by the *Plan*

L

Services provided and billed by a **lactation consultant**

M

Services or supplies deemed not ***medically necessary***

O

Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a *member* or for treatment of **obesity**, except for surgical treatment of morbid obesity, or as specifically covered by the *Plan*

P

Care or services from a ***provider*** who:

- Cannot legally provide or legally charge for the services or services are outside the scope of the *provider's* license or certification
- Provides and bills for services from a licensed health care professional who is in training
- Is in a *member's* immediate family.

WHAT IS NOT COVERED? *(cont.)*

R

The following **residential care** services:

- Care in a self-care unit, apartment or similar facility operated by or connected with a *hospital*
- Domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities, except for substance abuse treatment, or any similar facility or institution.

Respite care except as specifically covered by the *Plan*

S

Services or supplies that are:

- Not performed by or upon the direction of a *doctor* or *other provider*
- Available to a *member* without charge.

Treatment or studies leading to or in connection with **sex changes or modifications** and related care

Sexual dysfunction unrelated to organic disease

Shoe lifts and shoes of any type unless part of a brace

T

The following types of **therapy**:

- Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
- *Maintenance therapy*
- Massage therapy.

Travel, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the *Plan*

V

The following **vision** services:

- Radial keratotomy and other refractive eye *surgery*, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
- Eyeglasses or contact lenses, except as specifically covered in "*Prosthetic Appliances*"
- Orthoptics, vision training, and low vision aids.

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind except for external nutrition administered exclusively via tube feeding as the sole source of nutrition. External nutrition products that are administered orally are excluded.

UTILIZATION MANAGEMENT

To make sure you have access to high quality, cost-effective health care, the *Plan* has a *utilization management* (*UM*) program. The *UM* program requires that certain health care services be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are *medically necessary*, provided in the proper setting and for a reasonable length of time. **The *Plan* will honor a *certification* to cover *medical services* or supplies under the *Plan* unless the *certification* was based on a material misrepresentation about your health condition or you were not eligible for these services under the *Plan* due to termination of coverage or nonpayment of premiums.**

Rights And Responsibilities Under The *UM* Program

Your *Member* Rights

Under the *UM* program, you have the right to:

- A *UM* decision that is timely, meeting applicable federal time frames
- The reasons for BCBSNC's denial of a requested treatment or health care service, including an explanation of the *UM* criteria and treatment protocol used to reach the decision
- Have a medical director from BCBSNC make a review of all denials of service that were based upon *medical necessity*
- Request a review of denial of benefit coverage through the *grievance* process
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf.

An authorized representative may act on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under the "*Utilization Management*" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

BCBSNC's Responsibilities

As part of all *UM* decisions, BCBSNC will:

- Provide you and your *provider* with a toll-free telephone number to call *UM* review staff when *certification* of a health care service is needed
- Limit what BCBSNC requests from you or your *provider* to information that is needed to review the service in question
- Request all information necessary to make the *UM* decision, including pertinent clinical information
- Provide you and your *provider* prompt notification of the *UM* decision consistent with the *Plan*

In the event BCBSNC does not receive sufficient information to approve coverage for a health care service within specified time frames, BCBSNC will notify you in writing that benefit coverage has been denied. The notice will explain how you may pursue a review of the *UM* decision.

Prospective Review/*Prior Review*

The *Plan* requires that certain health care services receive *prior review* as noted in "*Covered Services.*" These types of reviews are called prospective reviews. **If neither you nor your *provider* requests *prior review* and receives *certification*, this may result in a partial or complete denial of benefits. General categories of services with this requirement are noted in "*Covered Services.*" You may also visit the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for a detailed list of these services. The list of services that require *prior review* may change from time to time.**

If the requested *certification* is denied, you have the right to appeal. See "What If You Disagree With A Decision?" for additional information. Certain services may not be covered *out-of-network*. See "*Covered Services.*"

BCBSNC will make a decision on your request for *certification* within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated within three business days after BCBSNC receives all necessary information but no later than 15 days from the date BCBSNC received the request. If your request is incomplete, then within five days from the date BCBSNC received your request, BCBSNC will notify you and your *provider* of how to properly complete your request. BCBSNC may also take an extension of up to 15 days if additional information is needed. BCBSNC will notify you and your *provider* before the end of the initial 15-day period of the information needed and the date by which BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a decision within three business days. If BCBSNC does not approve benefit coverage of a health care service, BCBSNC will notify you and the *provider* by written or electronic confirmation.

Expedited Prospective Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. BCBSNC will notify you and your *provider* of its decision as soon as possible, taking into account the medical circumstances. BCBSNC will notify you and your *provider* of its decision within 72 hours after receiving the request. If BCBSNC needs additional information to process your expedited review, BCBSNC will notify you and your *provider* of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the time period specified for you to provide the information, whichever

is earlier, BCBSNC will make a decision on your request within a reasonable time but no later than 48 hours. An expedited review may be requested by callingBCBSNC Customer Service at the number given in "Whom Do I Call?"

Concurrent Reviews

BCBSNC will also review health care services at the time you receive them. These types of reviews are concurrent reviews.

BCBSNC will communicate concurrent review decisions to the *hospital* or other facility within three business days after BCBSNC receives all necessary information but no later than 15 days after the request. If BCBSNC does not provide *certification* of a health care service, BCBSNC will notify you, your *hospital's* or other facility's *UM* department and your *provider*. Written confirmation of the decision will also be sent to your home by U.S. mail.

For concurrent reviews, the *Plan* will remain responsible for *covered services* you are receiving until you or your representatives have been notified of the denial of benefit coverage.

Expedited Concurrent Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. If you request an extension of treatment that BCBSNC has already approved at least 24 hours before the current approved treatment ends, BCBSNC will notify you and your *provider* of its decision as soon as possible taking into account the medical circumstances, but no later than 24 hours after receiving the request.

Retrospective Reviews

BCBSNC also reviews the coverage of health care services after you receive them (retrospective reviews). Retrospective review may include a review to determine if services received in an emergency setting qualify as an *emergency*. BCBSNC will make all retrospective review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date BCBSNC received the request. When the decision is to deny benefit coverage, BCBSNC will notify you and your *provider* in writing within five business days of the decision. All decisions will be based on *medical necessity* and whether the service received was a benefit under this *Plan*. BCBSNC may take an extension of up to 15 days if additional information is needed. Before the end of the initial 30-day period, BCBSNC will notify you of the extension, the information needed and the date by which BCBSNC expects to make a decision. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days. Services that were approved in advance by BCBSNC will not be subject to denial for *medical necessity* once the claim is received, **unless the *certification* was based on a material misrepresentation about your health condition or you were not eligible for these services under the *Plan* due to termination of coverage or nonpayment of premiums**. All other services may be subject to retrospective review and could be denied for *medical necessity* or for a benefit limitation or exclusion.

Care Management

Members with complicated and/or chronic medical needs may, solely at the option of BCBSNC, be eligible for care management services. Care management (or case management) encourages *members* with complicated or chronic medical needs, their *providers*, and the *Plan*, to work together to meet the individual's health needs and promote quality outcomes. To accomplish this, *members* enrolled in or eligible for care management programs may be contacted by BCBSNC or by a representative of BCBSNC. The *Plan* is not obligated to provide the same benefits or services to a *member* at a later date or to any other *member*. Information about these services can be obtained by contacting an *in-network PCP* or *in-network specialist* or by calling BCBSNC Customer Service.

Continuity Of Care

Continuity of care is a process that allows *members* with ongoing special conditions to continue receiving care from an *out-of-network provider*, when the *member's employer* changes plans or when their *provider* is no longer in the Blue Options network. If your *PCP* or *specialist* leaves the BCBSNC *provider* network and they are currently treating you for an ongoing special condition that meets BCBSNC continuity of care criteria, BCBSNC will notify you 30 days before the *provider's* termination, as long as BCBSNC receives timely notification from the *provider*. To be eligible for continuity of care, the *member* must be actively being seen by the *out-of-network provider* for an ongoing special condition and the *provider* must agree to abide by the *Plan's* requirements for continuity of care. An ongoing special condition means:

- in the case of an acute illness, a condition that is serious enough to require *medical care* or treatment to avoid a reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires *medical care* or treatment over a prolonged period of time;
- in the case of pregnancy, the second and third trimesters of pregnancy;
- in the case of a terminal illness, an individual has a medical prognosis that the *member's* life expectancy is six months or less.

The allowed transitional period shall extend up to 90 days, as determined by the *provider*, except in the cases of:

- scheduled *surgery*, organ transplantation, or *inpatient* care which shall extend through the date of discharge and post-discharge follow-up care or other *inpatient* care occurring within 90 days of the date of discharge; and

- second trimester pregnancy which shall extend through the provision of 60 days of postpartum care; and
- terminal illness which shall extend through the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be paid at the *member's in-network* benefit level. Continuity of care will not be provided when the *provider's* contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal. Please call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for additional information.

Further Review Of *Utilization Management* Decisions

If you receive a *noncertification* as part of the *prior review* process, you have the right to request that the *Plan* review the decision through the *grievance* process. Refer to "What If You Disagree With A Decision?"

Delegated *Utilization Management*

For *UM* and the first level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services, Magellan Behavioral Health is responsible. Claims determinations and second level *grievance* review are provided by BCBSNC.

Evaluating New Technology

In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new medical technology, procedures and equipment. These policies allow BCBSNC to determine the best services and products to offer *members*. They also help BCBSNC keep pace with the ever-advancing medical field. Before implementing any new or revised policies, BCBSNC reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. BCBSNC then seeks additional input from *providers* who know the needs of the patients they serve.

WHAT IF YOU DISAGREE WITH A DECISION?

In addition to the *UM* program, the *Plan* offers a *grievance* procedure for *members*. *Grievances* include dissatisfaction with a claims denial or any decisions (including an appeal of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services. If you have a *grievance*, you have the right to request that BCBSNC review the decision through the *grievance* process. The *grievance* process is voluntary and may be requested by the *member* or an authorized representative acting on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps To Follow In The *Grievance* Process

For each step in this process, there are specified time frames for filing a *grievance* and for notifying you or your *provider* of the decision. The review must be requested in writing, within 180 days of a denial of benefit coverage (the initial claim denial or the first level *grievance* review decision).

Any request for review should include:

- Employee's ID number
- Employee's name
- Any other information that may be helpful for the review
- Patient's name
- The nature of the *grievance*

To request a form to submit a request for review, visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

All correspondence related to a request for a review through BCBSNC's *grievance* process should be sent to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

In addition, members may also receive assistance with *grievances* from the Managed Care Patient Assistance Program by contacting:

Managed Care Patient Assistance Program
9001 Mail Service Center
Raleigh, NC 27699-9001
Tel: (919) 733-6272
Tel (toll free in NC): 1-866-867-6272
Email: MCPA@ncdoj.gov

Following such request for review, a review will be conducted by BCBSNC, by someone who is neither the individual who made the original claims denial that is the subject of the *grievance*, nor the subordinate of such individual. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations with respect to whether a particular treatment, drug or other item is *experimental, investigational*, or not *medically necessary* or appropriate, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

First Level Grievance Review

BCBSNC will provide you with the name, address and phone number of the *grievance* coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials. For *grievances* concerning quality of health care, an acknowledgement will be sent by BCBSNC within five business days.

Although you are not allowed to attend a first level *grievance* review, BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level *Grievance* Review

Since the *Plan* is subject to *ERISA*, the first level *grievance* review is the only level that you must complete before you can pursue your *grievance* in an action in federal court.

Otherwise, if you are dissatisfied with the first level *grievance* review decision, you have the right to a second level *grievance* review. Second level *grievances* are not allowed for benefits or services that are clearly excluded by this benefit booklet or quality of care complaints. Within ten business days after BCBSNC receives your request for a second level *grievance* review, the following information will be given to you:

- Name, address and telephone number of the *grievance* coordinator
- A statement of your rights, including the right to:

WHAT IF YOU DISAGREE WITH A DECISION? *(cont.)*

- request and receive from BCBSNC all information that applies to your case
- attend the second level *grievance* review meeting
- present your case to the review panel
- submit supporting material before and at the review meeting
- ask questions of any member of the review panel
- be assisted or represented by a person of your choosing, including a family member, an *employer* representative, or an attorney
- pursue other voluntary alternative dispute resolution options.

The second level review meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level *grievance* review request. You will receive notice of the meeting date and location at least 15 days before the meeting. You have the right to a full review of your *grievance* even if you do not attend the meeting. A written decision will be issued to you within five business days of the review meeting.

Notice Of Decision

If any claim (whether expedited or nonexpedited) shall be wholly or partially denied at either the first level *grievance* or the second level *grievance* review, a written notice shall be provided to the *member* worded in an understandable manner and shall set forth:

- The specific reason(s) for the denial
- Reference to the specific the *Plan* provisions on which the decision is based
- A statement that the *member* is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the *member's* claim for benefits
- If applicable, a statement describing any voluntary appeals procedures and the *member's* right to receive information about the procedures as well as the *member's* right to bring a civil action under Section 502(a) of *ERISA* following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request
- If the decision is based on *medical necessity* or *experimental* treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *member's* medical circumstances, or a statement that such explanation will be provided without charge upon request; and
- The following statement: "You 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."

Expedited Review

You have the right to a more rapid or expedited review of a denial of coverage if a delay: (i) would reasonably appear to seriously jeopardize your or your dependent's life, health or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling BCBSNC Customer Service at the number given in "Whom Do I Call?" An expedited review will take place in consultation with a medical *doctor*. All of the same conditions for a first level or second level *grievance* review apply to an expedited review, except that the review meeting will take place through a conference call or through written communication. BCBSNC will communicate the decision by phone to you and your *provider* as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

After requesting an expedited review, the *Plan* will remain responsible for covered health care services you are receiving until you have been notified of the review decision.

Correspondence related to a request for a review through the *Plan's grievance* process should be sent to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

Delegated Appeals

Magellan Behavioral Health is responsible for the first level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services. Please forward written *grievances* to:

Magellan Behavioral Health
Appeals Department
PO Box 1619

WHAT IF YOU DISAGREE WITH A DECISION? *(cont.)*

Alpharetta, GA 30009
Second level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services is provided by BCBSNC

Benefits To Which *Members* Are Entitled

The benefits described in this benefit booklet are provided only for *members*. These benefits and the right to receive payment cannot be transferred to another person. At the option of the *Plan*, payment for services will be made to the *provider* of the services, or the *Plan* may choose to pay the *participant*.

If a *member* resides with a custodial parent or legal guardian who is not the *participant*, the *Plan* will, at its option, make payment to either the *provider* of the services or to the custodial parent or legal guardian for services provided to the *member*. If the *participant* or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the *provider*.

Benefits for *covered services* specified in the *Plan* will be provided only for services and supplies that are performed by a *provider* as specified in the *Plan* and regularly included in the *allowed amount*. BCBSNC establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under the *Plan*.

Any amounts paid by the *Plan* for noncovered services or that are in excess of the benefit provided under your Blue Options coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a *member's* future claim payment. This can result in a reduction or elimination of future claims payments. Amounts paid by the *Plan* for work-related accidents, injuries, or illnesses covered under state workers' compensation laws will be recovered upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the *member*, the employer or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

Providers are independent contractors, and they are solely responsible for injuries and damages to *members* resulting from misconduct or negligence.

BCBSNC's Disclosure Of Protected Health Information (PHI)

BCBSNC takes your privacy seriously and handles all PHI as required by state and federal laws and regulations and accreditation standards. BCBSNC has developed a privacy notice that explains the procedures. To obtain a copy of the privacy notice, visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Administrative Discretion

BCBSNC has the authority to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning coverage of services, care, treatment or supplies, and reasonableness of charges. BCBSNC medical policies are guides considered when making coverage determinations.

Provider Reimbursement

BCBSNC has contracts with certain *providers* of health care services for the provision of, and payment for, health care services provided to all *members* entitled to health care benefits. BCBSNC's payment to *providers* may be based on an amount other than the actual charges, including without limitation, an amount per confinement or episode of care, agreed upon schedule of fees, or other methodology as agreed upon by BCBSNC and the *provider*. Under certain circumstances, a contracting *provider* may receive payments from BCBSNC greater than the charges for services provided to an eligible *member*, or BCBSNC may pay less than charges for services, due to negotiated contracts. The *member* is not entitled to receive any portion of the payments made under the terms of contracts with *provider*. The *member's* liability when defined as a percent of charge shall be calculated based on the lesser of the *allowed amount* or the *provider's* actual charge for *covered services* provided to a *member*.

Services Received In North Carolina

Some *out-of-network providers* have other agreements with BCBSNC that affect their reimbursement for *covered services* provided to Blue Options *members*. These *providers* agree not to bill *members* for any charges higher than their agreed upon, contracted amount. In these situations, *members* will be responsible for the difference between the Blue Options *allowed amount* and the contracted amount. *Out-of-network providers* may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

Services Received Outside Of North Carolina

Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the BlueCard program. Your *ID card* tells participating *providers* that you are a *member* of BCBSNC. By taking part in this program, you may receive discounts from out-of-state *providers* who participate in the BlueCard program.

When you obtain health care services through the BlueCard program outside the area in which the BCBSNC network operates, the amount you pay toward such *covered services*, such as *deductibles*, *copayments* or *coinsurance*, is usually based on the lesser of:

- The billed charges for your *covered services*, or
- The negotiated price that the out-of-state Blue Cross and/or Blue Shield licensee ("Host Blue") passes on to BCBSNC.

This "negotiated price" can be:

- A simple discount which reflects the actual price paid by the Host Blue
- An estimated price that factors in expected settlements, withholds, contingent payment arrangements, or other nonclaims transactions, with your health care *provider* or with a group of *providers*

- A discount from billed charges that reflects the **average** expected savings with your health care *provider* or with a group of *providers*. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

The estimated or average price may be adjusted in the future to correct for over- or under-estimation of past prices. However, the amount you pay is considered a final price.

Should any state enact a law that mandates liability calculation methods that differ from the usual BlueCard program method or requires a surcharge, your required payment for services in that state will be based upon the method required by that state's law.

Right Of Recovery Provision

Immediately upon paying or providing any benefit under the *Plan*, the *Plan* shall be subrogated to all rights of recovery a *member* has against any party potentially responsible for making any payment to a *member* due to a *member's* injuries, illness or condition, to the full extent of benefits provided or to be provided by the *Plan*.

In addition, if a *member* receives any payment from any potentially responsible party as a result of an injury, illness or condition, the *Plan* has the right to recover from, and be reimbursed by, the *member* for all amounts the *Plan* has paid and will pay as a result of that injury or illness, up to and including the full amount the *member* receives from all potentially responsible parties. The *member* agrees that if the *member* receives any payment from any potentially responsible party as a result of an injury or illness, the *member* will serve as a constructive trustee over the funds for the benefit of the *Plan*. Failure to hold such funds in trust will be deemed a breach of the *member's* fiduciary duty to the *Plan*.

Further, the *Plan* will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a *member* receives from any third party, any third party's insurer or any other source as a result of the *member's* injuries. The lien is in the amount of benefits paid by the *Plan* for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a *member* due to a *member's* injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The lien can be filed with or enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the *Plan* including, but not limited to, the *member*; the *member's* representative or agent; responsible party; responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the *Plan*.

The *member* acknowledges that the *Plan's* recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the *Plan* before any other claim for the *member's* damages. The *Plan* shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the *Plan* will result in a recovery to the *member* which is insufficient to make the *member* whole or to compensate the *member* in part or in whole for the damages sustained. It is further understood that the *Plan* will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the *Plan* is not required to participate in or pay court costs or attorney fees to any attorney hired by the *member*.

The terms of this entire right of recovery provision shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the *member* identifies the medical benefits the *Plan* provided. The *Plan* is entitled to recover from **any and all** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The *member* acknowledges that BCBSNC has been delegated authority by the *Plan Administrator* to assert and pursue the right of subrogation and/or reimbursement on behalf of the *Plan*. The *member* shall fully cooperate with BCBSNC's efforts to recover benefits paid by the *Plan*. It is the duty of the *member* to notify BCBSNC in writing of the *member's* intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the *member*. The *member* shall provide all information requested by BCBSNC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as BCBSNC may reasonably request.

The *member* shall do nothing to prejudice the *Plan's* recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by the *Plan*.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the *member* and the *Plan* agree that the *Plan Administrator* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The *member* agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as BCBSNC may elect. Upon receiving benefits under the *Plan*, the *member* hereby submits to each such jurisdiction, waiving whatever rights may correspond to the *member* by reason of the *member's* present or future domicile.

Notice Of Claim

The *Plan* will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that *covered services* have been provided to a *member*. If the *member* files the claim, written notice must be given to BCBSNC within 18 months after the *member incurs* the *covered service*, except in the absence of legal capacity of the *member*. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

Notice Of Benefit Determination

BCBSNC will provide an explanation of benefits determination to the *member* or the *member's* authorized representative within 30 days of receipt of a notice of claim if the *member* has financial liability on the claim other than a *copayment* (unless your *Plan* has chosen to provide an explanation of benefits for additional claims where the *member* does not have a financial liability other than a *copayment*). BCBSNC may take an extension of up to 15 additional days to complete the benefits determination if additional information is needed. If BCBSNC takes an extension, BCBSNC will notify the *member* or the *member's* authorized representative of the extension and of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days.

Such notice will be worded in an understandable manner and will include:

- The specific reason(s) for the denial of benefits
- Reference to the benefit booklet section on which the denial of benefits is based
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed
- A description of the review procedures and the time limits applicable to such procedures, including the *member's* right to bring a civil action under Section 502(a) of *ERISA* following a denial of benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request
- If the denial of benefits is based on *medical necessity* or *experimental* treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the health benefit plan to the *member's* medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of a denial of benefits involving *urgent care*, a description of the expedited review process available to such claims.

Upon receipt of a denial of benefits, you have the right to file a *grievance* with BCBSNC. See "What If You Disagree With A Decision?" for more information.

Limitation Of Actions

Since the *Plan* is subject to *ERISA*, you must only exhaust the first level *grievance* review process following the Notice of Claim requirement. Please see "What If You Disagree With A Decision?" for details regarding the *grievance* review process. No legal action may be taken later than three years from the date *covered services* are *incurred*. However, if you are authorized to pursue an action in federal court under *ERISA*, and you choose to pursue a second level *grievance* review, the three-year limitation is temporarily suspended until that review has been resolved.

Coordination Of Benefits (Overlapping Coverage)

If a *member* is also enrolled in another group health plan, the *Plan* may coordinate benefits with the other plan. Coordination of benefits (COB) means that if a *member* is covered by more than one insurance plan, benefits under one plan are determined before the benefits are determined under the second plan. The plan that determines benefits first is called the primary plan. The other plan is called the secondary plan. Benefits paid by the secondary plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service.

Most group health insurance plans include a COB provision. The rules used to determine which plan is primary and secondary are listed in the following chart. The "participant" is the person who is signing up for health insurance coverage.

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	Yes	
	The plan with COB is		Yes
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	Yes	
	The plan covering the person as a dependent is		Yes
The person is covered as a dependent child under both plans, including when parents are divorced or separated and share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	Yes	
	The plan of the parent whose birthday is later in the calendar year is		Yes
	Note: When the parents have the same birthday, the plan that covered the parent longer is	Yes	
The person is covered as a dependent child and parents are divorced or separated with no court decree for coverage	The custodial parent's plan is	Yes	
	The plan of the spouse of the custodial parent is		Yes
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	Yes	
	The non-custodial parent's plan is		Yes
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	Yes	
	The plan of the other parent is		Yes
	Note: If there is a court decree that requires a parent to assume financial responsibility for the child's health care coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent's health benefit plan are	Yes	
The person is covered as a laid-off or retired employee or that employee's dependent, on one of the plans	The plan that covers a person other than as a laid-off or retired employee or as that employee's dependent	Yes	
	The plan that covers a person as a laid-off or retired employee or the dependent of a laid-off or retired employee		Yes
	Note: This rule does not apply if it results in a conflict in determining order of benefits		
The person is the participant in two active group health plans and none of the rules above apply	The plan that has been in effect longer is	Yes	
	The plan that has been in effect the shorter amount of time is		Yes

NOTE: Payment by BCBSNC under the *Plan* takes into account whether or not the *provider* is a participating *provider*. If the *Plan* is the secondary plan, and the *member* uses a participating *provider*, the *Plan* will coordinate up to the *allowed amount*. The participating *provider* has agreed to accept the *allowed amount* as payment in full.

BCBSNC may request information about the other plan from the *member*. A prompt reply will help BCBSNC process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits are coordinated with other group health plans, benefits for *covered services* are still subject to program requirements, such as *prior review* and *certification* procedures.

DEFINITIONS

ALLOWED AMOUNT — the charge that BCBSNC determines is reasonable for *covered services* provided to a *member*. This may be established in accordance with an agreement between the *provider* and BCBSNC. In the case of *providers* that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the *provider's* actual charge or a reasonable charge established by BCBSNC using a methodology that is applied to comparable *providers* for similar services under a similar plan. BCBSNC's methodology is based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the *provider* may be combined into one procedure for reimbursement purposes.

AMBULANCE — transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured, includes ground and aircraft.

AMBULATORY SURGICAL CENTER — a *nonhospital facility* with an organized staff of *doctors*, which is licensed or certified in the state where located, and which:

a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an *outpatient* basis
b) Provides nursing services and treatment by or under the supervision of *doctors* whenever the patient is in the facility
c) Does not provide *inpatient* accommodations
d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a *doctor* or *other provider*.

BENEFIT PERIOD — the period of time, as stated in the "Summary Of Benefits," during which charges for *covered services* provided to a *member* must be *incurred* in order to be eligible for payment by the *Plan*. A charge shall be considered *incurred* on the date the service or supply was provided to a *member*.

BENEFIT PERIOD MAXIMUM — the maximum amount of charges for *covered services* in a *benefit period* that will be reimbursed on behalf of a *member* while covered under the *Plan*.

CERTIFICATION — the determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy BCBSNC's requirements for *medically necessary* services and supplies, appropriateness, health care setting, level of care and effectiveness.

COINSURANCE — the sharing of charges by the *Plan* and the *member* for *covered services* received by a *member*, usually stated as a percentage of the *allowed amount*.

COINSURANCE MAXIMUM — the maximum amount of *coinsurance* that a *member* is obligated to pay for *covered services* per *benefit period*.

COMPLICATIONS OF PREGNANCY — medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated prior to the full term of the pregnancy (except as otherwise stated below), including, but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. *Emergency* cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as a complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy.

CONGENITAL — existing at, and usually before, birth referring to conditions that are apparent at birth regardless of their causation.

COPAYMENT — the fixed-dollar amount that is due and payable by the *member* at the time a *covered service* is provided.

COSMETIC — to improve appearance. This does not include restoration of physiological function resulting from accidental injury, trauma or previous treatment that would be considered a *covered service*. This also does not include reconstructive *surgery* to correct *congenital* or developmental anomalies that have resulted in functional impairment.

COVERED SERVICE(S) — a service, drug, supply or equipment specified in this benefit booklet for which *members* are entitled to benefits in accordance with the terms and conditions of the *Plan*.

CREDITABLE COVERAGE — accepted health insurance coverage carried prior to BCBSNC coverage can be group health insurance, self-funded plans, individual health insurance, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as creditable coverage under state or federal law. Creditable coverage does not include coverage consisting solely of excepted benefits.

CUSTODIAL CARE — care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by BCBSNC without regard to the place of service or the *provider* prescribing or providing the services.

DEDUCTIBLE — the specified dollar amount for certain *covered services* that the *member* must incur before benefits are payable for the remaining *covered services*. The deductible does not include *copayments*, *coinsurance*, charges in excess of the *allowed amount*, amounts exceeding any maximum and expenses for noncovered services.

DEFINITIONS *(cont.)*

DENTAL SERVICE(S) — dental care or treatment provided by a *dentist* or *other professional provider* in the *dentist's* office to a covered *member* while the policy is in effect, provided such care or treatment is recognized by BCBSNC as a generally accepted form of care or treatment according to prevailing standards of dental practice.

DENTIST — a dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide *dental services,* perform dental *surgery* or administer anesthetics for dental *surgery.* All services performed must be within the scope of license or certification to be eligible for reimbursement.

DEVELOPMENTAL DYSFUNCTION — difficulty in acquiring the activities of daily living including, but not limited to, walking, talking, feeding or dressing oneself or learning in school. Developmental therapies are those to facilitate or promote the development of skills, which the *member* has not yet attained. Examples include, but are not limited to: speech therapy to teach a *member* to talk, follow directions or learn in school; physical therapy to treat a *member* with low muscle tone or to teach a *member* to roll over, sit, walk or use other large muscle skills; occupational therapy to teach a *member* the activities of daily living, to use small muscle skills or balance or to assist with behavior or achievement in the learning setting.

DOCTOR — includes the following: a doctor of medicine, a doctor of osteopathy, licensed to practice medicine or *surgery* by the Board of Medical Examiners in the state of practice, a doctor of dentistry, a doctor of podiatry, a doctor of chiropractic, a doctor of optometry, or a doctor of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner or scope of practice. All services performed must be within the scope of license or certification to be eligible for reimbursement.

DURABLE MEDICAL EQUIPMENT — items designated by BCBSNC which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home.

EFFECTIVE DATE — the date on which coverage for a *member* begins, according to "When Coverage Begins And Ends."

EMERGENCY(IES) — the sudden or unexpected onset of a condition of such severity 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 an individual or with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock, and other severe, acute conditions are examples of emergencies.

EMERGENCY SERVICES — health care items and services furnished or required to screen for or treat an *emergency* medical condition until the condition is *stabilized,* including pre-hospital care and ancillary services routinely available in the emergency department.

EMPLOYER — Duke Energy Corporation or an affiliated company that is participating in the *Plan.*

ERISA — the Employee Retirement Income Security Act of 1974.

EXPERIMENTAL — see *Investigational.*

FACILITY SERVICES — *covered services* provided and billed by a *hospital* or *nonhospital facility.* All services performed must be within the scope of license or certification to be eligible for reimbursement.

GRIEVANCE — grievances include dissatisfaction with a claims denial or any decisions (including an appeal of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services.

HOLISTIC MEDICINE — unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any *other provider.*

HOMEBOUND — a *member* who cannot leave their home or temporary residence due to a medical condition which requires both the assistance of another person and the aid of supportive devices or the use of special transportation. A *member* is not considered homebound solely because the assistance of another person is required to leave the home.

HOME HEALTH AGENCY — a *nonhospital facility* which is primarily engaged in providing home health care services medical or therapeutic in nature, and which:

a) Provides skilled nursing and other services on a visiting basis in the *member's* home,
b) Is responsible for supervising the delivery of such services under a plan prescribed by a *doctor,*
c) Is accredited and licensed or certified in the state where located,
d) Is certified for participation in the Medicare program, and
e) Is acceptable to BCBSNC.

HOSPICE — a *nonhospital facility* that provides medically related services to persons who are terminally ill, and which:

a) Is accredited, licensed or certified in the state where located,
b) Is certified for participation in the Medicare program, and
c) Is acceptable to BCBSNC.

HOSPITAL — an accredited institution for the treatment of the sick that is licensed as a hospital by the appropriate state agency in the state where located. All services performed must be within the scope of license or certification to be eligible for reimbursement.

IDENTIFICATION CARD (ID card) — the card issued to *members* upon enrollment which provides *employer/member* identification numbers, names of the *members,* applicable *copayments* and/or *coinsurance,* and key phone numbers and addresses.

INCURRED — the date on which a *member* receives the service, drug, equipment or supply for which a charge is made.
INFERTILITY — the inability of a heterosexual couple to conceive a child after 12 months of unprotected male/female intercourse.
IN-NETWORK — designated as participating in the Blue Options network. BCBSNC's payment for in-network *covered services* is described in this benefit booklet as in-network benefits or in-network benefit levels.
IN-NETWORK PROVIDER — a *hospital, doctor*, other medical practitioner or *provider* of *medical services* and supplies that has been designated as a Blue Options *provider* by BCBSNC or a *provider* participating in the BlueCard program.
INPATIENT — pertaining to services received when a *member* is admitted to a *hospital* or *nonhospital facility* as a registered bed patient for whom a room and board charge is made.
INVESTIGATIONAL (EXPERIMENTAL) — the use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, drug, or device that BCBSNC does not recognize as standard *medical care* of the condition, disease, illness, or injury being treated. The following criteria are the basis for BCBSNC's determination that a service or supply is investigational:

a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply
c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
d) The service or supply under consideration is not as beneficial as any established alternatives
e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

If a service or supply meets one or more of the criteria, it is deemed investigational except for clinical trials as described under the *Plan*. Determinations are made solely by BCBSNC after independent review of scientific data. Opinions of experts in a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered by BCBSNC but are not determinative or conclusive.
LICENSED PRACTICAL NURSE (LPN) — a nurse who has graduated from a formal practical nursing education program and is licensed by the appropriate state authority.
LIFETIME MAXIMUM — the maximum amount of *covered services* that will be reimbursed on behalf of a *member* while covered under the *Plan*.
MAINTENANCE THERAPY — services that preserve your present level of function or condition and prevent regression of that function or condition. Maintenance begins when the goals of the treatment plan have been achieved and/or when no further progress is apparent or expected to occur.
MEDICAL CARE/SERVICES — professional services provided by a *doctor* or *other provider* for the treatment of an illness or injury.
MEDICAL SUPPLIES — health care materials that include ostomy supplies, catheters, oxygen and diabetic supplies.
MEDICALLY NECESSARY (or MEDICAL NECESSITY) — those *covered services* or supplies that are:

a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under the *Plan*, not for *experimental, investigational*, or *cosmetic* purposes,
b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms,
c) Within generally accepted standards of *medical care* in the community, and
d) Not solely for the convenience of the insured, the insured's family, or the *provider*.

For medically necessary services, BCBSNC may compare the cost-effectiveness of alternative services, settings or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.
MEMBER — an *participant* or dependent, who is currently enrolled in the *Plan* and for whom premium is paid.
MENTAL ILLNESS — mental disorders, psychiatric illnesses, mental conditions and psychiatric conditions (whether organic or non-organic, whether of biological, nonbiological, chemical or nonchemical origin and irrespective of cause, basis or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC.)
NONCERTIFICATION — a determination by BCBSNC that a service covered under the *Plan* has been reviewed and does not meet BCBSNC's requirements for *medical necessity*, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of *emergency services* and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is *experimental, investigational* or *cosmetic* is considered a noncertification. A noncertification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

DEFINITIONS *(cont.)*

NONHOSPITAL FACILITY — an institution or entity other than a *hospital* that is accredited and licensed or certified in the state where located to provide *covered services* and is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.
OFFICE VISIT — *medical care, surgery,* diagnostic services, *short-term rehabilitative therapy* services and *medical supplies* provided in a *provider's* office.
OTHER PROFESSIONAL PROVIDER — a person or entity other than a *doctor* who is accredited and licensed or certified in the state where located to provide *covered services* and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.
OTHER PROVIDER — an institution or entity other than a *doctor* or *hospital,* which is accredited and licensed or certified in the state where located to provide *covered services* and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.
OTHER THERAPY(IES) — the following services and supplies, both *inpatient* and *outpatient,* ordered by a *doctor* or *other provider* to promote recovery from an illness, disease or injury when provided by a *doctor, other provider* or professional employed by a *provider* licensed in the state of practice.

a) Cardiac rehabilitative therapy — reconditioning the cardiovascular system through exercise, education, counseling and behavioral change
b) Chemotherapy (including intravenous chemotherapy) — the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the Food and Drug Administration (FDA)
c) Dialysis treatments — the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis
d) Pulmonary therapy — programs that combine exercise, training, psychological support and education in order to improve the patient's functioning and quality of life
e) Radiation therapy — the treatment of disease by x-ray, radium, or radioactive isotopes
f) Respiratory therapy — introduction of dry or moist gases into the lungs for treatment purposes.

OUT-OF-NETWORK — not designated as participating in the Blue Options network, and not certified in advance by BCBSNC to be considered as *in-network*. Payment for out-of-network *covered services* is described in this benefit booklet as out-of-network benefits or out-of-network benefit levels.
OUT-OF-NETWORK PROVIDER — a *provider* that has not been designated as a Blue Options *provider* by BCBSNC.
OUTPATIENT — pertaining to services received from a *hospital* or *nonhospital facility* by a *member* while not an *inpatient*.
OUTPATIENT CLINIC(S) — an accredited institution/facility associated with or owned by a *hospital*. An outpatient clinic may bill for *outpatient* visits, including professional services and ancillary services, such as diagnostic tests. These services may be subject to the *Outpatient* Services benefit. All services performed must be within the scope of the professional or facility license or certification to be eligible for reimbursement.
PARTICIPANT — a person who is eligible for coverage under the *Plan* and properly enrolled.
PLAN — Duke Energy Medical Plan's Preferred Provider Organization (PPO) option.
PLAN ADMINISTRATOR — Duke Energy Benefits Committee.
PLAN SPONSOR — Duke Energy Corporation.
POSITIONAL PLAGIOCEPHALY — the asymmetrical shape of an infant's head due to uneven external pressures on the skull in either the prenatal or postnatal environment. This does not include asymmetry of an infant's head due to premature closure of the sutures of the skull.
PREVENTIVE CARE — *medical services* provided by or upon the direction of a *doctor* or *other provider* related to the prevention of disease.
PRIMARY CARE PROVIDER (PCP) — an *in-network provider* who has been designated by BCBSNC as a PCP.
PRIOR REVIEW — the consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of *medical necessity* of services and supplies, appropriateness, health care setting, or level of care and effectiveness. Prior review results in *certification* or *noncertification* of benefits.
PROSTHETIC APPLIANCES — fixed or removable artificial limbs or other body parts, which replace absent natural ones following permanent loss of the body part.
PROVIDER — a *hospital, nonhospital facility, doctor,* or *other provider,* accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification. All services performed must be within the scope of license or certification to be eligible for reimbursement.
REGISTERED NURSE (RN) — a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program), and is licensed by the appropriate state authority in the state of practice.
ROUTINE FOOT CARE — hygiene and preventive maintenance such as trimming of corns, calluses or nails that do not usually require the skills of a qualified *provider* of foot care services.
SEXUAL DYSFUNCTION — any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.
SHORT-TERM REHABILITATIVE THERAPY — services and supplies both *inpatient* and *outpatient,* ordered by a *doctor* or *other provider* to promote the recovery of the *member* from an illness, disease or injury when provided by a *doctor, other*

provider or professional employed by a *provider* licensed by the appropriate state authority in the state of practice and subject to any licensure or regulatory limitation as to location, manner or scope of practice.

a) Occupational therapy — treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role after such ability has been impaired by disease, injury or loss of a body part
b) Physical therapy — treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part
c) Speech therapy — treatment for the restoration of speech impaired by disease, *surgery*, or injury; or certain significant physical *congenital* conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

SKILLED NURSING FACILITY — a *nonhospital facility* licensed under state law that provides skilled nursing, rehabilitative and related care where professional *medical services* are administered by a registered or *licensed practical nurse.* All services performed must be within the scope of license or certification to be eligible for reimbursement.

SPECIALIST — a *doctor* who is recognized by BCBSNC as specializing in an area of medical practice.

STABILIZE — to provide *medical care* that is appropriate to prevent a material deterioration of the *member's* condition, within reasonable medical certainty.

SURGERY — the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures, such as:

a) The correction of fractures and dislocations
b) Usual and related pre-operative and post-operative care
c) Other procedures as reasonable and approved by BCBSNC.

TRANSPLANTS — the surgical transfer of a human organ or tissue taken from the body for grafting into another area of the same body or into another body; the removal and return into the same body or transfer into another body of bone marrow or peripheral blood stem cells. Grafting procedures associated with reconstructive *surgery* are not considered transplants.

URGENT CARE — services provided for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis or treatment, such that in the absence of immediate care the individual could reasonably be expected to suffer chronic illness, prolonged impairment, or require a more hazardous treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

UTILIZATION MANAGEMENT (UM) — a set of formal processes that are used to evaluate the *medical necessity,* quality of care, cost-effectiveness and appropriateness of many health care services, including procedures, treatments, medical devices, *providers* and facilities.

WAITING PERIOD — the amount of time that must pass before a *member* is eligible to be covered for benefits under the terms of the *Plan.*

BlueCross BlueShield of North Carolina

MEMBER'S AUTHORIZATION REQUEST FORM
COMMERCIAL OPERATIONS / IDC

You may give Blue Cross and Blue Shield of North Carolina (BCBSNC) written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that BCBSNC communicates with members or subscribers.** ***For example, we will send explanation of benefits (EOB) statements to the subscriber.***

MEMBER WHOSE INFORMATION WILL BE DISCLOSED:

MEMBER'S FIRST NAME | M.I. | MEMBER'S LAST NAME

MONTH / DAY / YEAR — MEMBER'S DATE OF BIRTH

PREFIX | 9 DIGIT IDENTIFIER | SUFFIX — SUBSCRIBER ID NUMBER *(FROM YOUR ID CARD)*

At my request, I authorize BCBSNC to disclose Protected Health Information to ***(enter name of person/entity who will receive member's PHI)*****:**

FIRST NAME | M.I. | LAST NAME

RELATIONSHIP TO MEMBER:

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: **(i)** your subscriber ID number, **(ii)** your date of birth, and **(iii)** subscriber address.

I authorize BCBSNC to disclose the following PHI to the person/entity listed above. CHECK ONLY BOXES THAT APPLY:

☐ ALL Information Requested ☐ Enrollment Information ☐ Benefit Information ☐ Premium Payment Information ☐ Explanation of Benefits (EOB) Information

☐ All Claims Information ☐ All Services from a Specific Health Care Provider(s) *(List Provider's Name)*: _____

☐ Other *(Please List Specific PHI and/or Date Ranges)*: _____

If you want to authorize someone to have access to your mental health or substance abuse PHI, please call the mental health/substance abuse company's telephone number on the back of your membership card to request a separate authorization form from them.

NOTE: BCBSNC will consider the effective date of this authorization to be the date BCBSNC enters this authorization into its Commercial Operations business system, typically five (5) days following receipt.

If you would like this authorization to become effective on a date after BCBSNC enters the authorization into its system, please insert the date here: → MONTH / DAY / YEAR

I would like this authorization to expire on ***(enter date)*****:** MONTH / DAY / YEAR **OR** ☐ **When my policy expires.**

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)

I understand that I may revoke this authorization at any time by giving BCBSNC written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will not affect any action BCBSNC took in reliance on this authorization before BCBSNC received my written notice of revocation.

I also understand that BCBSNC will not condition the provision of health plan benefits on this authorization.

I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature: _____ **Today's Date:** MONTH / DAY / YEAR

If signed by an individual other than the member: _____
PRINT YOUR FULL NAME

Describe your authority to act for the member ***(e.g., power of attorney, court order, parent of minor child, etc.)*****:**

_____

NOTE: Please attach the legal document naming you as the personal representative if you have not previously submitted it to us.

RETURN THIS AUTHORIZATION TO: Commercial Operations / IDC
Blue Cross and Blue Shield of North Carolina
P.O. Box 2291 • Durham, NC 27702-2291

U2516, 1/04

SUMMARY OF BENEFITS

This section provides a summary of your Blue Options benefits. A more complete description of your benefits is found in "*Covered Services.*" General exclusions may also apply — please see "What Is Not Covered?" As you review the "Summary Of Benefits" chart, keep in mind:

- Services subject to a *copayment* are not subject to *deductible* and *coinsurance*
- *Copayment* amounts are fixed dollar amounts the *member* must pay for some *covered services*
- Multiple *office visits* or emergency room visits on the same day may result in multiple *copayments*
- *Coinsurance* percentages shown in this section are the portion of the *allowed amount* that the *Plan* covers
- *Deductible* and *coinsurance* amounts are based on the *allowed amount*
- Services applied to the *deductible* also count toward any visit or day maximums
- To receive *in-network* benefits, you must receive care from a Blue Options *in-network provider.* **However, in an *emergency*, or when *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, you may also receive *in-network* benefits for care from an *out-of-network provider.* Please see "*Out-Of-Network* Benefits" and "*Emergency* Services" for additional information. Access to care standards are available on the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or by calling BCBSNC Customer Service at the number listed on your *ID Card* or in "Whom Do I Call?"**
- If you see an *out-of-network provider,* you will receive *out-of-network* benefits unless otherwise approved by BCBSNC.

Please note: The list of *in-network providers* may change from time to time, so please verify that the *provider* is still in the Blue Options network before receiving care. Find a *provider* on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed on your *ID card* or in "Whom Do I Call?"

SPECIAL NOTICE IF YOU CHOOSE AN *OUT-OF-NETWORK PROVIDER*

NOTICE: Your actual expenses for *covered services* may exceed the stated *coinsurance* percentage or *copayment* amount because actual *provider* charges may not be used to determine the *Plan's* and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount,* in addition to any *copayment* or *coinsurance* amount.

Benefit period January 1 through December 31

Benefit payments are based on where services are received and how services are billed.

	In-network	*Out-of-network*
Physician Office Services		
See *Outpatient* Services for *outpatient clinic* or *hospital*-based services. *Office visits* for the evaluation and treatment of obesity are limited to a combined in- and *out-of-network* maximum of four visits per *benefit period.*		
Office Services		
Primary Care Provider	$25 *copayment*	$25 *copayment*
Specialist	$35 *copayment*	$35 *copayment*
Includes office *surgery,* x-rays and lab tests.		
CT Scans, MRIs, MRAs and PET Scans	90% after *deductible*	90% after *deductible*
Preventive Care		
Primary Care Provider	$25 *copayment*	$25 *copayment*
Specialist	$35 *copayment*	$35 *copayment*
Includes routine physical exams, well baby, well-child care, immunizations, gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests (PSAs).		

SUMMARY OF BENEFITS *(cont.)*

	In-network	*Out-of-network*
Physician Office Services (con't)		
Short-term Rehabilitative Therapies	$35 *copayment*	$35 *copayment*
Chiropractic Services	$35 *copayment*	$35 *copayment*
Combined in- and *out-of-network benefit period maximums* apply to home, office and *outpatient* settings. 80 visits per *benefit period* for speech therapy, physical/occupational therapy, and chiropractic services combined.		
Other Therapies	100%	100%
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See *Outpatient* Services for *other therapies* provided in an *outpatient* setting.		
***Infertility* and *Sexual Dysfunction* Services**		
Primary Care Provider	$25 *copayment*	$25 *copayment*
Specialist	$35 *copayment*	$35 *copayment*
Routine Eye Exam	$35 *copayment*	$35 *copayment*
***Urgent Care* Centers and Emergency Room**		
***Urgent Care* Centers**	$50 *copayment*	$50 *copayment*
Emergency Room Visit	$75 *copay*, then 90% after *deductible*	$75 *copay*, then 90% after *deductible*
If admitted to the *hospital* from the emergency room, *inpatient hospital* benefits apply to all *covered services* provided. If held for observation, *outpatient* benefits apply to all *covered services* provided. If you are sent to the emergency room from an *urgent care* center, you may be responsible for both the emergency room *coinsurance* and the *urgent care copayment*.		
Ambulatory Surgical Center	90% after *deductible*	90% after *deductible*
***Outpatient* Services**		
Physician Services	90% after *deductible*	90% after *deductible*
***Hospital* and *Hospital*-based Services**	90% after *deductible*	90% after *deductible*
***Outpatient Clinic* Services**	90% after *deductible*	90% after *deductible*
***Outpatient* Diagnostic Services:**		
Outpatient lab tests and mammography, when performed alone	100%	100%
Outpatient lab tests and mammography, when performed with another service	90% after *deductible*	90% after *deductible*
Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	90% after *deductible*	90% after *deductible*
CT scans, MRIs, MRAs and PET scans	90% after *deductible*	90% after *deductible*
Therapy Services	90% after *deductible*	90% after *deductible*
Includes *short-term rehabilitative therapies* and *other therapies including dialysis; see* Physician Office Services for visit maximums.		

SUMMARY OF BENEFITS *(cont.)*

	In-network	*Out-of-network*
***Inpatient Hospital* Services**		
Physician Services	90% after *deductible*	90% after *deductible*
***Hospital* and *Hospital*-based Services**	90% after *deductible*	90% after *deductible*
Includes maternity delivery, prenatal and post-delivery care. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new *deductible* for *covered services* from *doctors* or *other professional providers*.		
Skilled Nursing Facility	90% after *deductible*	90% after *deductible*
Combined in- and *out-of-network* maximum of 60 days per *benefit period*. Services applied to the *deductible* count towards this day maximum.		
Other Services	90% after *deductible*	90% after *deductible*
Includes *ambulance, durable medical equipment, hospice* services, *medical supplies*, orthotic devices, private duty nursing, *prosthetic appliances*, and *home health* care. Orthotic devices for correction of *positional plagiocephaly* are limited to a *lifetime maximum* of $600.		

Lifetime Maximum, Deductible, and *Coinsurance Maximum*

The following *deductibles* and maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.

Lifetime Maximum	Unlimited	Unlimited
Unlimited for all services, except orthotic devices for *positional plagiocephaly, infertility* and *sexual dysfunction* and substance abuse.		
Deductible		
Individual, per *benefit period*	$400	$400
Family, per *benefit period*	$800	$800

Charges for the following do not apply to the *benefit period deductible:*

- *inpatient* newborn care for well baby
- mental health and substance abuse services.

Coinsurance Maximum		
Individual, per *benefit period*	$1,500	$1,500
Family, per *benefit period*	$3,000	$3,000

Charges for the following do not apply to the *benefit period coinsurance maximum:*

- mental health and substance abuse services.

SUMMARY OF BENEFITS *(cont.)*

	In-network	*Out-of-network*

Penalty For Failure To Obtain *Certification*

Certain services require *prior review* and *certification* by BCBSNC in order to receive benefits. You are responsible for requesting or ensuring that your *provider* requests *prior review* by BCBSNC. **Failure to request *prior review* and receive *certification* may result in allowed charges being reduced by 50% or full denial of benefits. See "Prospective Review/*Prior Review*" in "*Utilization Management.*"**

Prior review and *certification* by Magellan Behavioral Health are required for *inpatient* and *outpatient* mental health and substance abuse services, except for *emergencies*. Please see the number in "Whom Do I Call?"

Mental Health And Substance Abuse Services

Prior review and *certification* by Magellan Behavioral Health are required for *inpatient* and *outpatient* services. Please see the number in "Whom Do I Call?"

Mental Health Office Services Combined in- and *out-of-network* limit of 30 *office visits* per *benefit period*.	$35 *copayment*	$35 *copayment*
Mental Health *Inpatient/Outpatient* Services Combined in- and *out-of-network* limit of 30 days per *benefit period*.	90% after *deductible*	90% after *deductible*
Substance Abuse Office Services	$35 *copayment*	$35 *copayment*
Substance Abuse *Inpatient/Outpatient* Services	90% after *deductible*	90% after *deductible*
Substance Abuse *Benefit Period Maximum*	None	
Substance Abuse *Lifetime Maximum*	$16,000	

Prescription Drug Program Guide for Duke Energy Medical Plan

medco® manages your prescription drug benefit for Duke Energy.

Prescription Drug Program

The Duke Energy Medical Plan options include outpatient prescription drug coverage currently administered by Medco Health Solutions, Inc. ("Medco"). Medco is a national pharmacy benefit manager with participating retail pharmacies that include Wal-Mart, Rite Aid, Walgreens, CVS, and others. The prescription drug program can help you save on medically necessary prescribed medications at retail pharmacies and through **Medco By Mail**, a home delivery pharmacy service.

Through the prescription drug coverage, you can:

- Purchase up to a 30-day supply of prescription medications at a participating retail pharmacy.
- Use **Medco By Mail** for up to a 90-day supply of prescription medications.
- Use online resources at www.medco.com to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- Reach Medco Member Services representatives, 24 hours a day, 7 days a week (except Thanksgiving and Christmas when holiday schedules apply) at 1-800-987-8361. Pharmacists are also available around the clock for medication consultations.

Medical Plan and Health Care Spending Account

(Applicable only to active employees)

The prescription drug program copays do not apply to your Medical Plan deductible or coinsurance maximum, if applicable. 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 amounts and copays with before-tax dollars by filing for reimbursement from your HCSA, using your HCSA debit card, or through the HCSA automatic reimbursement feature.

Retail Prescription Drug Program Deductible for Catastrophic Coverage Option

(Applicable only to certain retirees)

If you are enrolled in the Medical Plan's Catastrophic B coverage option, each covered individual has a $200 annual individual retail prescription drug deductible for prescription purchases made at participating retail pharmacies. The $200 deductible is separate from the Medical Plan's Catastrophic B coverage option deductible. Each covered person must meet the annual deductible before the prescription drug program copays apply to retail prescription drug purchases for that person. When you make retail prescription drug purchases at a participating pharmacy that are applied toward the prescription drug annual deductible, you will pay 100% of Medco's negotiated price for the medication that you are purchasing.When you reach the point where the amount of a prescription drug purchase will allow you to meet your annual deductible, you will pay the remaining amount of the deductible and the applicable copay amount.

For example, if the amount of your prescription purchase is $90 and there is $25 remaining to meet your annual deductible, you will pay $25, which is applied to the deductible, and the applicable copay amount for the purchase of the prescription drug.

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 for each person. You may also call Medco's Member Services to determine the portion of the deductible that has been satisfied to date.

If you are enrolled in any option other than the Medical Plan's Catastrophic B option, you are not required to satisfy an annual deductible before the prescription drug program copays apply to retail prescription drug purchases.

Formulary

Your prescription drug program includes a tiered formulary. A formulary is a list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings for the member and the Medical Plan. Due to the tiered formulary, your copay amount for prescription purchases will vary depending on whether your physician prescribes a generic, preferred brand-name or non-preferred brand-name medication. By asking your physician to prescribe generic or preferred brand-name medications, you can help control rising health care costs.

To find out whether a medication is included in the tiered formulary, visit Medco online at www.Medco.com. If you are a first time visitor to the site, please take a moment to register. Please have your member ID number available. After you log in, click "Learn about formularies" in the "Prescriptions & benefits" section. Search for a specific drug to determine if it is on the formulary. A formulary guide is included in your Medco Welcome Kit and you may also call Medco Member Services and request that a formulary guide be mailed to your home. See the prescription drug program summary of benefits for more information about applicable copays for generic, preferred brand-name and non-preferred brand-name medication.

Filling Your Prescription at a Retail Pharmacy

You can fill a prescription at a retail pharmacy for up to a 30-day supply. You will simply show your Medco ID card (with the Medco group number) at the time of your purchase. After meeting any applicable deductibles, you will pay the applicable prescription drug copay.

- If you don't identify yourself to the pharmacist as a Medco participant, or if you go to a non-participating pharmacy, you will have to pay the full price when you pick up the prescription and then submit a paper claim to Medco for reimbursement. You will be reimbursed based on the Medco negotiated price for the medication, less any required deductible and copay. Retail pharmacies that participate in the Medco retail pharmacy 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 Medco 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 participating retail pharmacy and do not identify yourself as a Medco participant by presenting your Medco 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 Medco ID card and ask the pharmacist to submit the order using the original dispensing date. Please confirm that 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 copay. This process will eliminate your need to submit a paper claim to Medco for reimbursement.

Retail Refill Allowance (Mandatory Mail) After Three Retail Refills

Generally, a 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 the Medical Plan's prescription drug program, you must use **Medco By Mail** to receive prescription coverage benefits for your maintenance medication purchases. Here's how it works:

- Beginning with the 4th retail fill of a covered maintenance medication, you will pay the entire cost of that maintenance medication if you continue to purchase it at a participating retail pharmacy. However, if you use Medco's mail-order service, **Medco By Mail**, you will pay the applicable mail order copay amount for up to a 90-day supply.
- The first three times that you purchase each maintenance medication at a participating retail pharmacy, you will pay your participating retail pharmacy copay (for members enrolled in the Medical Plan's Catastrophic B coverage option, the deductible must be met before the copay will apply). After that, you will pay the entire cost of each maintenance medication unless you choose to order through **Medco By Mail.**
- You should continue to purchase your prescriptions for short-term use, such as antibiotics, at a participating retail pharmacy. You'll pay the applicable participating retail pharmacy copay for up to a 30-day supply.

The list of maintenance medications that are addressed by the Retail Refill Allowance provision is subject to change at any time. Visit **www.medco.com** and click "Price a medication" to find out whether your medication is considered a maintenance medication and whether it is affected by any plan limits, or you may call Medco directly for more information.

Using Medco By Mail

The prescription drug program includes **Medco By Mail**, a home delivery pharmacy service, which offers a greater discount on the cost of maintenance medication and a larger supply (up to a 90-day supply) per prescription. Refer to the Retail Refill Allowance section above for a description of what constitutes a maintenance medication. To use **Medco By Mail**:

1. Ask your physician to prescribe your maintenance medication for up to a 90-day supply, plus refills for up to one year, if appropriate.
2. Mail your prescription, along with an order form and the required copay, to Medco. Order forms are available online on the Duke Energy Portal and at **www.medco.com**, or you may call Medco to request a supply of order forms.
3. Once you have established your prescription through **Medco By Mail**, you can order refills online. You will need to enter your member number (from your Medco ID card), enter the prescription number for the medication you wish to refill and verify your address. A detailed summary of your order, including costs, will be available for viewing online. Similar information will be included with your prescription when it is mailed to you.
4. You may also ask your physician to call **1-888-EASYRX1 (1-888-327-9791)** for instructions on how to fax the prescription. Remember to give your physician your Member ID and Medco group numbers (as shown on your Medco ID card); both numbers will be required for your prescription order.

If your prescription is written for less than a 90-day supply, the prescription will be filled in accordance with the day supply your physician ordered, but you will pay the entire **Medco By Mail** copay. If the medication is a federal legend, maintenance medication, a Medco pharmacist will review the prescription

and notify you if the prescription is less than the maximum days' supply available at mail. The pharmacist will offer to contact your physician on your behalf to obtain a new prescription. Please note there are certain situations that may preclude the pharmacist from contacting you directly, such as if the medication is a controlled substance, a specialty drug, or a compounded prescription.

Your prescription will be delivered to your home within 14 calendar days. With a **Medco By Mail** prescription, you will receive materials explaining the purpose of the drug, correct dosages and other helpful information. **When a prescription is ordered using Medco By Mail, Medco will automatically dispense the generic equivalent if one is available and permissible by law, unless your physician has indicated that substitution is not allowed.**

Send mail order prescriptions to:
Medco Mail Order Pharmacy
PO BOX 650322, Dallas TX 75265

Accredo Health Group – Medco's Specialty Care Pharmacy

Specialty medications are typically injectable medications administered either by you or a healthcare professional, and they often require special handling.

Conditions and therapies for which specialty medications are typically used include:

- Age-related macular degeneration
- Alpha-1 proteinase deficiency
- Anemia
- Anti-infective therapy
- Asthma
- Cancer
- Cystic fibrosis
- Deep vein thrombosis
- Fabry disease
- Gaucher disease
- Growth hormone deficiency
- Hemophilia
- Hepatitis C
- Hereditary tyrosinemia
- HIV
- Hyperparathyroidism
- Immune deficiency
- Infertility
- Insulin-like growth factor therapy
- Iron chelation therapy
- Mucopolysaccharidosis
- Multiple sclerosis
- Neutropenia
- Osteoarthritis
- Osteoporosis
- Parkinson disease
- Pompe disease
- Psoriasis
- Pulmonary hypertension
- Respiratory syncytial virus
- Rheumatoid arthritis

Under your prescription drug program, some specialty medications may *not* be covered at participating retail pharmacies or through **Medco By Mail**, but instead may only be covered when ordered through ***Accredo Health Group***, Medco's specialty care pharmacy. Accredo is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling. Services include:

- Toll-free access to specially trained pharmacists 24 hours a day, 7 days a week
- Personalized counseling from our dedicated team of registered nurses and pharmacists
- Expedited, scheduled delivery of your medications at no extra charge
- Refill reminder calls

- Coordination of home care and other healthcare services
- Free supplies, such as needles and syringes, to administer your medication

To find out whether any of your specialty medications need to be ordered through Accredo, please call Medco Member Services at the toll-free number on your prescription drug ID card.

Medicare Part B Medications

(Applicable only to Medicare Part B enrollees)

If you are eligible for Medicare Part B coverage and use a participating Medicare Part B retail pharmacy, you may not have to incur out-of-pocket expenses for your Medicare Part B-eligible medications and supplies*. Medicare Part B-eligible prescriptions may be filled through the **Medco By Mail** mail-order pharmacy or at a participating Medicare Part B retail pharmacy. In either case, the pharmacy will verify coverage and file your prescription claims with Medicare, and bill you if any balance is due. For more information about Medicare Part B coverage, call Medco Member Services toll-free at 1-800-987-8361, or visit **www.Medco.com.**

**Medicare Part B coverage will begin only after you have paid your Medicare deductible.*

Some of the medications and supplies typically covered by Medicare Part B include:

- Diabetic supplies (test strips, meters)
- Medications to aid tissue acceptance from Medicare-covered organ transplants
- Certain oral medications used to treat cancer
- Certain medications used in situations where the kidneys have completely failed

If you have Medicare Part B coverage, you will be able to fill prescriptions like these in one of two ways:

- **Medicare Part B Mail-Order Pharmacy**—When using mail order for your medication or supply needs, you will initially send your prescription to **Medco By Mail**. Then, depending on the type of medication or supply requested, **Medco By Mail** will transfer your prescription information to one of two Medicare Part B participating mail-order pharmacies—**Liberty Medical** or **Accredo Health Group**, Medco's specialty care pharmacy. Both Liberty and Accredo have extensive experience with Medicare Part B and will support the dispensing and billing of your prescriptions. They will verify coverage, file your prescription claim with Medicare, and bill you for any balance due. Depending on the covered medications or supplies that you need, Liberty or Accredo will mail your Medicare Part B medications and supplies directly to you and provide instructions for obtaining refills.
- **Medicare Part B Retail Pharmacy**—When using a participating 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 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 Coordination of Benefits processing is available and coordinated by the Part B providers. The provider will submit claims on behalf of the member to Medicare for processing as primary. Once payment is received from Medicare, the Part B provider will submit a secondary claim to Medco and the claim will process under the secondary benefit, if that is offered (for example, Medicare would pay 80% of the claim as primary, and the client would pay 20% of the claim as secondary).

A word about prescriptions covered by Medicare Part B
For more details about which medications or supplies are Medicare Part B–eligible and to learn more about your Medicare coverage:

- Visit the Medicare website at **www.medicare.gov**.
- Call Medicare Customer Service at **1 800 MEDICARE** (1 800 633-4227).

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 **Medco By Mail** or at a participating retail pharmacy (using your Medco 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.

Generic Drugs

For prescription medications, the brand-name is the product name under which a drug is advertised and sold. Generic equivalent medications contain the same active ingredients and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name counterparts. Generally, generic drugs cost less than a brand-name drug. Whenever appropriate, you should ask your physician to prescribe generic drugs. Sometimes your physician may prescribe a medication as "dispense as written" when a preferred brand-name or generic equivalent drug is available. As part of your prescription drug program, the pharmacist may discuss with your physician whether an equivalent generic or preferred brand-name drug might be appropriate for you. The final decision on your medication always rests with you and your physician, even if that decision results in a higher cost to you for your prescription medication.

Covered Expenses

The following are covered expenses unless listed as an exclusion below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes (covered at a $0 copay)
- Over-the-Counter (OTC) Diabetic Supplies (lancets, insulin syringes and needles are covered at $0 copay)
- Oral, Transdermal, Intravaginal and Injectable Contraceptives
- Drugs to Treat Impotency (all dosage forms except Yohimbine) for males age 18 and over
- Yohimbine (covered without the limits that exist for other impotency products)
- Inhaler Assisting Devices
- Peak flow meters
- Synagis/Respigam
- Hemophilia Factors
- Fertility Agents (100% covered after standard copay, up to $2500 per person per lifetime, then member pays 50% of the cost of the drug)
- Zyban and Chantix (limit of 180 days of therapy per year and 360 days of therapy per lifetime)

- Substance abuse treatments
- Dental Fluoride Products
- Anti obesity Agents (covered **Medco By Mail** only)
- Products packaged as greater than a 30 days supply are covered at mail only

Coverage limits for Certain Medications

Your prescription drug program may have certain coverage limits. For example, some quantities may be limited or some prescriptions require a coverage review. Examples of drugs with limitations or requiring coverage review are Provigil, Human Growth Hormones, Impotency Products, and Proton Pump Inhibitors (Prevacid, Protonix, Aciphex, Zegerid). Refer to www.Medco.com or call member services at 1-800-987-8361 for details.

Dispensing Limits

- The amount of drug which is to be dispensed per prescription or refill (regardless of dosage form) will be in quantities prescribed up to a 30-day supply at a participating retail pharmacy and up to a 90-day supply through **Medco By Mail**
- Thalomid limited to a 28 day supply at both retail and **Medco By Mail**

Excluded Expenses

The following are excluded from coverage 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 under the Medical Plan)
- Glucowatch Products
- Anti-obesity meds at retail
- 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
- Biologicals, Immunization agents or Vaccines
- Blood or blood plasma products
- 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 any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member
- 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

Coordination of Benefits for the Prescription Drug Program

Under the prescription drug program, Medco 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 deductible and coinsurance, you may want to use your Medco ID Card, instead of your spouse/domestic partner's plan, to obtain your prescriptions.

Please Note: Medco does coordinate benefits for Medicare Part B. Please see section titled "Medicare Part B Medications" for more details.

How to File a Prescription Drug Program Claim

When you fill your prescription at a participating retail pharmacy and identify yourself as a Medco 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, if any, and the copay.

If you do not identify yourself to the pharmacist as a Medco participant, or if you do not use a participating pharmacy, you will need to file a claim for reimbursement of your prescription drug expenses through Medco. 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, the cost, the strength, quantity, and days supply of medication, the name of the medication, prescription number and NDC number. When you submit an original receipt, keep a copy for your records. Claim reimbursement is limited to Medco's discounted price less any required deductible and copay. Medco 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 prescription medication on January 15, 2009, from a non-participating pharmacy, you must file your claim by April 15, 2010, to receive reimbursement for your expenses. Duke Energy offers new Medco prescription participants a 45-day grace period for prescription drug claims purchased at full cost in situations where the prescription ID card was not used. The grace period allows members to be reimbursed at 100%, less the applicable deductible and copay, for paper claims submitted within 45 days from a participant's initial eligibility effective date with Medco. For example, a participant who's initial effective date with Medco is January 1, 2009 would have 45 days (until February 14, 2009) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether the pharmacy was a participating or non-participating.

To obtain a claim form, call Medco Member Services at 1-800-987-8361, or go online to **www.medco.com**.

Submit claim forms to:
Medco Health Solutions, Inc.
PO Box 14711
Lexington, KY 40512

Reviews & Appeals

Medco will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Medco's control, it will notify you or your representative within 15 days after receiving the request. The extension notice will include 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 Medco 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 45 days to respond to the request for information.

Notice of Adverse Determination

In the event of an adverse benefit determination, in whole or in part, you (or your authorized representative) 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 plan benefit. An adverse benefit determination notification for any prescription drug plan claim will contain:

- 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 review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; and
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim.

When You Have a Complaint or an Appeal

If your claim is denied, you may request a full review by Medco within 180 days of the date of the adverse benefit determination. Your written letter of appeal should include the following:

- your name and member 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 Medco 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 Medco in reviewing your claim. You may request reasonable access to copies of all documents, records, and other information relevant to your claim. Medco 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. Your appeal should be mailed to:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving TX 75063
1-800-987-8361

Medco will notify you of its decision on your appeal within 15 days of its receipt of your 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:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and the claimant's right to bring an action under ERISA section 502(a);
- upon request and free of charge, reasonable access will be provided to copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal.

Second Level Appeal Process

If your claim is denied on appeal, you have a right to bring a second 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. Medco 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.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or Duke Energy 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.

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 Appeals Procedure. You may not initiate a legal action until you have completed the first and second level 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

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 Medco's 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 Medco at the address listed above.
Call Medco Member services for additional information regarding the appeals process.

This is a guide of covered expenses and expenses not covered under the prescription drug program. For more information about applicable deductibles, copays and plan limits, please call Medco Member Services or visit www.Medco.com. For more detailed information on the Medical Plan, refer to the Duke Energy Medical Plan General Information Booklet and BCBSNC Benefits Booklet sections of this Summary Plan Description. The official plan documents govern plan provisions and payment of plan benefits.

medco®

SUMMARY OF PRESCRIPTION DRUG BENEFITS

Annual Deductible (per person*) – *applies to retail pharmacy purchases*	$0	
Prescription Drug Co-pays		
You must show your Medco ID card	**Retail Pharmacy (up to a 30-day supply)**	**Mail Order (up to a 90-day supply)**
Generic	$10	$25
Preferred Brand	$20	$50
Non-Preferred Brand	$40	$100

*There is no annual family prescription drug deductible.

Medical Plan Benefits

Exclusive Provider Organization (EPO) option #1

Duke Energy®

Inside you will find:

- SECTION I: Duke Energy Medical Plan—General Information
- SECTION II: BCBSNC Benefit Booklet (includes Summary of Medical Benefits)
- SECTION III: Medco Prescription Drug Guide
- SECTION IV: Summary of Prescription Drug Benefits

The Duke Energy Medical Plan
General Information

IMPORTANT NOTICE

This General Information booklet for The Duke Energy 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 election 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 2009 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

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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, pharmacy, wellness and disease management benefits.

Based on your location and employee or retiree group, there are various Medical Plan coverage options available, such as exclusive provider organization (EPO), preferred provider organization (PPO) and high-deductible health plan (HDHP) options. If you do not have adequate access to network providers, you may qualify for out-of-area (OOA) options that mirror the PPO options. All of the Medical Plan options are designed to help you pay for health care expenses.

myHR Service Center

If you have any questions about the Medical Plan or the information in this General Information booklet, contact the myHR Service Center at 1-888-465-1300. Representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time. Information is also available through the Your Benefits Resources™ (YBR) Web site 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 (collectively referred to with Duke Energy as the "Company") 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.

International Assignment

When you are assigned by your Company to work outside the U.S. for a period that is initially expected to last at least nine consecutive months, you will cease to be eligible for the Medical Plan options available to employees on U.S. domestic assignment.

Instead, you will be eligible for the Medical Plan's special international assignment coverages. These coverages are described in a special booklet and not in the Medical Plan's General Information booklet or the other Medical Plan booklets.

Eligible Retirees

If your employment terminates on or after January 1, 2009, to be eligible for retiree coverage under the Medical Plan, at termination of employment you must:

- be employed by a Company that offers access to retiree coverage under the Medical Plan; and
- be at least age 50 and credited with at least 5 years of retiree eligibility service.

Contact the myHR Service Center if you want to know if a particular Company offers access to retiree coverage under the Medical Plan.

If your Company employment terminated before January 1, 2009, 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 for your eligible spouse and/or child(ren). If you are a Legacy Duke employee[†] who retires on or after January 1, 2006, you may be eligible to elect coverage for your eligible domestic partner. If you are a Legacy Duke employee who retired before January 1, 2006, or if you are a Legacy Cinergy retiree[‡], you are not eligible to elect coverage for your domestic partner. Please refer to the sections *Enrolling in the Medical Plan – Eligible Retirees* and *Mid-Year Coverage Changes* for additional information.

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)[*]

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."

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, which may include "common law marriage," and the spouse must meet the federal tax requirement of being a person of the opposite sex who is the taxpayer's husband or wife.

[†] When used in this booklet, the term "Legacy Duke" refers to an individual who (1) terminated employment with Duke Energy Corporation, a North Carolina corporation, and its affiliates prior to the merger of Cinergy Corp. and Duke Energy Corporation, a North Carolina corporation, (2) was employed by Duke Energy Corporation, a North Carolina corporation, and its affiliates immediately prior to such merger or (3) except as provided in footnote 2 below, was hired following such merger by a payroll company that was affiliated with (or has been designated as having been affiliated with) Duke Energy Corporation, a North Carolina corporation, immediately prior to such merger.

[‡] When used in this booklet, the term "Legacy Cinergy" refers to an individual who (1) terminated employment with Cinergy Corp. and its affiliates prior to the merger of Cinergy Corp. and Duke Energy Corporation, a North Carolina corporation, (2) was employed by Cinergy Corp. and its affiliates immediately prior to such merger, (3) was hired following such merger by a payroll company that was affiliated with (or has been designated as having been affiliated with) Cinergy Corp. immediately prior to such merger or (4) was hired by Duke Energy Business Services, LLC on or after July 1, 2008 at a work location such that he or she would have been employed by Duke Energy Shared Services, Inc. if he or she was hired to work at such location immediately prior to July 1, 2008 and he or she is so designated as Legacy Cinergy in accordance with rules prescribed by the Plan Administrator.

[§] See *Eligible Retirees* for information regarding eligible retirees' ability to elect coverage for a domestic partner.

[*] A child of divorced parents will generally be recognized by Section 152(e) of the Internal Revenue Code as a dependent of both parents for purposes of coverage under the Medical Plan.

By enrolling a spouse, you represent that the individual meets these requirements. You must immediately drop coverage for a spouse who no longer meets these requirements.

Domestic Partner Eligibility

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

- be in an ongoing, exclusive and committed relationship with one another of mutual caring and support, in which each is responsible for the other's welfare and which is intended to continue indefinitely;
- be at least 18 years old and mentally competent to enter into a legal contract;
- reside together in a joint household for the preceding 6 consecutive months;
- share financial obligations of, and be jointly responsible for, the joint household;
- not be legally married to or legally separated from anyone else, and not be in a domestic partnership with anyone else; and
- not be blood relatives to a degree where marriage would be prohibited.

Child Eligibility

Your child is:

- your biological child; **or**
- your legally adopted child, including a child placed in your home for adoption by you as long as the child remains in your home and the adoption procedure has not been terminated (a legally adopted child will not qualify as a dependent if the child has reached age 18 as of the date of adoption or placement for adoption); **or**
- a stepchild for whom you or your spouse has full or joint custody or managing conservatorship; **or**
- any other child related to you by blood or marriage or for whom you or your spouse has court-appointed legal guardianship or managing conservatorship, who is living in your household on a substantially full-time basis, who you claim as a dependent for federal income tax purposes, and with whom you have a regular parent/child relationship.

In addition to meeting the above requirements, a child must also meet the following eligibility criteria:

- Unmarried; **and**
- Primarily dependent on you for support; **and**
- Less than age 19 if not a full-time student; **or**

** See *Eligible Retirees* for information regarding eligible retirees' ability to elect coverage for a domestic partner.

- Less than age 25 if a full-time student at an accredited educational institution taking nine or more hours per term; **or**
- Any age if he or she became physically or mentally incapable of self-support while enrolled in the Medical Plan and before reaching the applicable limiting age of 19 or 25 and continuously remains incapacitated and enrolled in the Medical Plan; **or**
- Any age if he or she was physically or mentally incapable of self-support on your date of employment with the Company, was enrolled in the Medical Plan as of your employment date and continuously remains incapacitated and enrolled in the Medical Plan.

In addition, your child must meet the Internal Revenue Code requirements for tax-free health coverage to be eligible for coverage in the Medical Plan.

By enrolling a dependent child, you represent that the individual satisfies these requirements. You must immediately drop coverage for a dependent child who no longer meets these requirements.

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

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

You may be required to provide evidence of dependent eligibility, such as, but not limited to, a marriage license, divorce decree, birth certificate, court order, adoption papers, certificate/affidavit of common-law marriage or proof of joint residency. Verification of a dependent child's full-time student status may be requested at age 19 and each year beyond age 19.

To continue coverage beyond age 19 for a child who is physically or mentally incapable of self-support, you must provide evidence of your child's incapacity to the applicable Claims Administrator. The application can be obtained by contacting the 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 graduates from college), the individual(s) who become(s) ineligible for coverage will be dropped from your coverage.

You must immediately report that any dependents 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 myHR Service Center that your dependent is no longer eligible.

If you do not inform the 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 elections (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 elections);

- 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, go to the myHR link on the Duke Energy Portal or contact the 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 – Eligible Employees

When You Are First Eligible

When you are eligible to enroll as an employee, you will make your Medical Plan elections 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 elections, contact the 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.

You may also decline coverage altogether.

During Annual Enrollment

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

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, 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).

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 election change occurs (see *Mid-Year Coverage 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 life event for which you can make a change in your Medical Plan elections (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.

Enrolling in the Medical Plan – Eligible Retirees

When You Are First Eligible

If you are an eligible retiree as described in *Eligible Retirees*, 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[††];
- Individual + Child(ren); or
- Individual + Family (spouse and child(ren))

You must make your election within 31 calendar days of becoming eligible for retiree coverage.

When you are eligible to enroll as a retiree, you can make your Medical Plan elections using an online enrollment tool. You will receive additional information about the online enrollment tool when you become eligible. You can also make your Medical Plan elections by contacting the myHR Service Center.

If you have any questions or need assistance in making your enrollment elections, contact the myHR Service Center.

[††] See *Eligible Retirees* for information regarding your ability to elect coverage for a domestic partner.

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 election 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 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 election changes are allowed.

Please refer to *During Annual Enrollment* and *Mid-Year Coverage Changes* for additional information.

During Annual Enrollment

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

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. When your employment terminates, you may reelect retiree coverage; however, unless you were represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA, you will not receive additional service credit for the time you worked as an active employee after your rehire date for purposes of determining your eligibility for or the amount of any Company contribution towards the cost of retiree medical coverage, either in the form of subsidized monthly coverage under the Medical Plan or Health Reimbursement Account benefits.

Cost of Coverage

Active Employees

If you are an active employee, 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 Web site.

Paying for Coverage as an Active Employee

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 a domestic partner under the Medical Plan is deducted on a pre-tax basis. On pay advice statements, the contribution amount for your coverage will appear as a pre-tax deduction and the contribution amount for your domestic partner will appear as imputed income.

While the Company subsidy amount for domestic partner coverage under the Medical Plan is the same as for spousal coverage, the subsidy amount for domestic partner coverage is reported each pay period as imputed income to the employee and is subject to applicable taxes.

Non-tobacco user discounts may be available for certain active employee Medical Plan coverage options. To qualify for applicable non-tobacco user discounts, you and all covered dependents must not have used tobacco products, including smokeless tobacco, during the 12 months prior to the effective date of your coverage. When you enroll, you will be asked to indicate if the non-tobacco user discount applies.

Non-Tobacco User Discount – Alternate Procedure for Active Employees in Certain Medical Plan Options

If you (or your covered dependent) are unable, due to a medical condition, to meet the requirements for the non-tobacco user discount (or if it is medically inadvisable for you to attempt to meet the requirements for the non-tobacco user discount), you may still apply to receive the discount by providing these two items:

1. A written statement from your (or your covered dependent's) physician stating that you (or your covered dependent) have a medical condition that makes it unreasonably difficult (or medically inadvisable) for you (or your covered dependent) to meet the requirements for the non-tobacco user discount. This statement should identify the health factor, explaining why the health factor makes it unreasonably difficult (or medically inadvisable) for you (or your covered dependent) to meet the requirements for the discount, and recommending a specific tobacco-cessation program that is appropriate for you (or your covered dependent), and
2. Either of the following:
   - A written statement from the recommended tobacco-cessation program stating that you (or your covered dependent) are either currently enrolled or that you (or your covered dependent) have completed the program within the last 12 months, or
   - If it is your initial year of claiming the discount in accordance with this procedure, a written certification from you that you (or your covered dependent) will enroll in the tobacco-cessation program recommended by your (or your dependent's) physician within the next three months.

In order to continue the non-tobacco user discount under this procedure, a new physician's statement and a new tobacco cessation program's statement will be required each year. In order

for you to qualify for the non-tobacco user discount, you and each of your covered dependents will have to meet the requirements for the discount or satisfy the alternate procedure.

If you would like to apply for the non-tobacco user discount under the alternate procedure, you should indicate at enrollment that you are a tobacco user and then contact the myHR Service Center to discuss remitting the information required under the alternate procedure. All information must be received within 31 calendar days of the date you become an eligible employee or, in the case of enrollment during a future annual enrollment period, by the deadline communicated in your annual enrollment materials. You will pay tobacco user rates until your alternate procedure application has been approved, at which time the non-tobacco user discount will be applied on a prospective basis as soon as administratively practicable.

Retirees

If you are an eligible retiree, the cost of your retiree coverage under the Medical Plan is based on the Medical Plan coverage option that you elect and the eligible dependent(s) you choose to cover. The portion of that cost that you must pay depends on multiple factors, including your date of hire, your date of termination and your retiree group. As described below, you may be eligible for a Company contribution towards the cost of retiree medical coverage, either in the form of subsidized monthly coverage under the Medical Plan or Health Reimbursement Account benefits. Information about contribution amounts is available through the YBR Web site.

If you were hired before January 1, 2009, you may be eligible for a Company contribution towards the cost of retiree medical coverage if you terminate employment after satisfying all applicable requirements. Your eligibility for Company contributions is governed by the eligibility rules in effect at the time of your date of 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 hired on or after January 1, 2009 (including most rehired employees) and you subsequently terminate your employment with the Company as an eligible retiree, you will not be eligible for a Company contribution toward the cost of retiree medical coverage and will be responsible for paying the full cost of any retiree coverage you elect under the Medical Plan, unless you are represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA, in which case the rules directly above for individuals hired before January 1, 2009 continue to apply to you.

If you are rehired on or after January 1, 2009 and you subsequently terminate your employment with the Company as an eligible retiree, you will be eligible for a Company contribution towards the cost of retiree medical coverage only if you satisfied the eligibility requirements for Company contributions toward the cost of retiree medical coverage in effect at the time of your previous 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. The rules described in this paragraph do not apply to individuals represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA. If you are represented by one of these unions, the rules directly above for individuals hired before January 1, 2009 continue to apply to you.

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.
- You also have the option to pay contributions in advance for the quarter (three months); semi-annually or for the entire year. If you later drop coverage for any reason, your unused contributions will be refunded. Contact the myHR Service Center to set up alternate billing arrangements.
- 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 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 myHR Service Center.

If you would like to change your payment method, contact the myHR Service Center.

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 are two months behind but have been sending in partial payments, or
- you call the 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.

Reinstatement after non-payment is possible if you contact the 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.

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 elections as a newly eligible employee or retiree, coverage begins on the date you become eligible (assuming that you make your elections within 31 calendar days of becoming eligible). Deductions for your contributions (or payment for your

coverage, in the case of eligible retirees) begin as soon as administratively practicable following the date that you make your elections.

Mid-Year Coverage Changes

As a covered active employee or retiree, 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 that 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 myHR link located on the Duke Energy Portal or by contacting the myHR Service Center.

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

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 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 myHR Service Center within 31 calendar days of a loss of eligibility.

If you are eligible to make changes, the elections 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 marries or turns 19 and is not a full-time student)

- a QMCSO is received*
- your child dies

- You begin or end an international assignment scheduled for at least nine months
- 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
- You or your dependent's COBRA coverage from another employer expires
- You or your dependent becomes entitled to or loses Medicare or Medicaid*
- 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

When Mid-Year Election and Contribution Changes Are Effective

The following chart shows when coverage and contributions change if you notify the myHR Service Center of a work/life event within 31 calendar days of the event.

Election Change	Coverage	Contributions
Start or increase coverage	Coverage changes on the day the work/life event occurred (Event Date)	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*
Decrease or stop coverage (your elective decrease or coverage termination)**	Coverage changes on the first day of the month after your Election Date*	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*
Decrease coverage due to a covered individual becoming ineligible for coverage (for example, divorce, child is age 19 and not a full-time student)***	Coverage for individuals no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage (Event Date)	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*

* Court Orders. 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 may also make an election change to cancel medical coverage for the child if the order requires the child's other parent to provide coverage.

* 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.

Election Change	Coverage	Contributions
* Your Election Date is the date you submit your election changes. **Does not include termination of employment. *** Does not include death. If you die, coverage ends on the date of your death.		

Situations Impacting Your 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 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 Insurance Plan or pay under the Sick Time Pay Benefit, you may be eligible for continued coverage under the Medical Plan. Contact the 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, your Medical Plan coverage will continue as long as you remain an eligible employee and pay any required contributions, and your coverage will be primary to Medicare.

If You Become Entitled to Medicare

If you are not actively at work and you become entitled to Medicare, you will be required to enroll in an option that coordinates with Medicare. Contact the 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 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 or as an eligible retiree;
- the last day of the month in which you cease to be an eligible employee, 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 the Company informs the Claims Administrator that you (while you are still eligible) are canceling Medical Plan coverage; or
- when 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. Medical Plan coverage will actually terminate, but will be reinstated retroactive to the coverage termination date if your 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.

When your coverage ends, you will receive a certificate of coverage that indicates the length of time you had coverage under the Medical Plan to the extent required by applicable law. You may need this certificate of coverage when enrolling in another plan. With this certificate, the time you were covered may be credited toward any pre-existing condition limitations in your new plan, provided you are enrolled in the new plan within 63 days of losing your Medical Plan coverage.

Benefits if You Die

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 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 myHR Service Center.

This provision applies even if your spouse 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 that any dependents 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 when your spouse/domestic partner either does or does not report a dependent's loss of eligibility within 31 calendar days of the loss of eligibility. To drop coverage for ineligible dependents, your spouse/domestic partner should go to the YBR Web site or contact the myHR Service Center.

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.

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, go to the myHR link on the Duke Energy Portal or contact the myHR Service Center.

If You Leave the Company

If your employment with the Company terminates, your coverage under the Medical Plan will end, unless you elect to continue coverage under COBRA or as an eligible retiree.

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

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 COBRA continuation coverage under the terms of COBRA, to maintain consistent administration, Duke Energy will apply the same rules to a domestic partner as to a spouse.

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,
- entitlement to Medicare, 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*.)

Bankruptcy Proceeding

If you are a retired employee and you or your eligible dependents lose coverage resulting from a bankruptcy proceeding against your Company, you may qualify for continuation coverage under COBRA.

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. The disability must last at least until the end of the 18-month period of continuation coverage.

You must notify the myHR Service Center in writing within the initial 18-month coverage period and within 60 days of the Social Security Administration's determination. Your verbal notice is not binding until confirmed in writing and the myHR Service Center receives a copy of the Social Security disability determination. You must also notify the 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, 2009, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2010, 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, 2012; or
- 18 months following your termination of employment - July 1, 2011

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2012 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 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 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;
- you become entitled to Medicare;
- you or an eligible dependent is determined to be disabled by the Social Security Administration

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

Duke Energy'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 will also 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 used 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 will also affect continued coverage under COBRA. You will be notified prior to 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. (If the other plan limits coverage of a pre-existing condition, COBRA coverage may be continued in certain circumstances).

Pre-existing Condition Limitation

If you become covered under another group medical plan and are affected by a pre-existing condition limitation under that plan, COBRA coverage may continue for that condition until you have satisfied the pre-existing condition limitation, as long as you remain within the COBRA period. When you are eligible for full benefits under your new plan, your COBRA coverage will be terminated.

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.

Medical Child Support Orders

If the Company receives notification that, as a result of a Qualified Medical Child Support Order, 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 may also sign claim forms and assign benefits to providers. The Claims Administrator will send notification of payment to 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 these guidelines:

- 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.
- 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
526 South Church Street
Charlotte, NC 28202
704-594-6200
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 plan number assigned to the Medical Plan is 502.

Funding

Benefits under the Medical Plan generally are provided from funds held by trustees. All Medical Plan claims except for post-retirement coverage for non-key employees are paid from the Duke Energy Corporation Welfare Benefits Trust VEBA I with Mellon Bank NA as trustee. Claims for post-retirement coverage for non-key employees are paid from the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II with Mellon Bank, NA as trustee. The address for Mellon Bank, NA is:

Mellon Bank, NA
One Mellon Bank Center
Pittsburgh, PA 15258

The Company may also provide benefits under the Medical Plan through insurance or from its general assets, and may also transfer assets from the 401(h) retiree account under the Duke Energy Corporation Master Retirement Trust to the Medical Plan to provide benefits for post-retirement coverage for non-key employees.

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy 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 the Claims Committee, which serves 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 and the Claims Committee may be contacted as follows:

Benefits Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285
704-594-6200

Claims Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285
704-594-6200

The Benefits Committee has appointed the Claims Administrators, which 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 can also obtain additional information by contacting the myHR Service Center.

The Benefits Committee, the Claims Committee and the Claims Administrators, 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 and the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II is the Duke Energy Investment Committee. The Chief Executive Officer of Duke Energy Corporation, or its delegate, appoints the Chairman of the Investment Committee, who in turn appoints the other members of the Investment Committee.

The Investment Committee oversees the maintenance and investment of plan assets for which it is named fiduciary, selects investment managers and collective investment funds, issues investment guidelines and objectives and monitors investment performance. The Investment Committee may be contacted through the following address:

Investment Committee
General Manager, Long Term Investments
Duke Energy Corporation
526 South Church Street, EC04Z
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:

Vice President, Legal
139 East Fourth Street - Room 25 ATII
P.O. Box 960
Cincinnati, OH 45201-0960
(513) 419-1851

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

Affiliated Employers of the Company That Have Adopted the Medical Plan

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

Claim Determination Procedures Under ERISA

The following are two different types of claims that may be made under the Medical Plan:

- claims for Medical Plan benefits; and
- 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 Medical Plan option (referred to as an "Eligibility or Enrollment Claim").

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 can also obtain additional information by calling the 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

Authority to decide an Eligibility or Enrollment Claim is assigned for initial claims to Duke Energy Human Resources, which is the Initial Claim Administrator. Human Resources has delegated its authority to the Hewitt Associates Benefits Determination Review Team. For denied claims on review, authority is assigned to the Duke Energy Claims Committee, which is the Denied Claim Reviewer.

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 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 the Benefit Determination Review Team within 90 days after the end of the plan year in which you are claiming eligibility/enrollment should have occurred.

The Benefits Determination Review Team 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 the Benefit Determination Review Team's control, it will notify you or your representative within 30 days after receiving the request. The extension notice will include 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 the Benefits Determination Review Team 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 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;
- 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 Medical Plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse determination on appeal;
- 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; and
- if the adverse determination is based on a medical necessity or experimental or investigative treatment, either a clinical or scientific explanation of the determination, applying the terms of the Medical Plan to your medical circumstances, or a statement that such clinical or scientific explanation will be provided free of charge upon request.

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.

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

Claims Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285

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. Someone other than an individual involved in the initial determination, or a subordinate of such individual, will make the determination on appeal.

You will be notified regarding the decision on your claim within 60 days. The determination of your appeal will be in writing and, if adverse, will contain the following:

- the specific reasons for the adverse determination of your appeal;
- 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 statement regarding your right to sue under Section 502(a) of ERISA following an adverse determination on your appeal 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 or investigative treatment, either a clinical or scientific explanation of the determination, applying the terms of the Medical Plan to your medical circumstances, or a statement that such clinical or scientific explanation will be provided free of charge upon request; and
- the 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."

After completing all mandatory appeal levels, you have the right to further appeal adverse determinations by bringing a civil action under ERISA. Please refer to the *Statement of ERISA Rights* section below.

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 Appeals 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 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 Denied Claim Reviewers' decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or 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.

Right to Change or Terminate the Medical Plan

Duke Energy 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 is also 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, 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 the Board of Directors, 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 insurance contracts, collective bargaining agreements and 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 insurance contracts and 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 person under 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* 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 summary plan description and the documents governing the Medical Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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 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 your 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 may also 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 myHR Service Center, if applicable, if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child marries, ceases to be a full-time student or is otherwise no longer an eligible dependent, contact the myHR Service Center as soon as possible. Certain work/life events allow you to change benefit elections that you previously made, but to do so, you must make the benefit election change within 31 calendar days of the work/life event.

A Final Note

Although this SPD describes the principal features of the Medical Plan that are generally applicable, it 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 be amended only by proper corporate action and not by oral or written communications about benefits under the Medical Plan.

Neither the Medical Plan, this SPD, nor your Medical Plan participation is an employment contract, and does 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.

Benefit Booklet

Benefit Booklet
For Participants of
Duke Energy Medical Plan
for

BlueOPTIONS℠

EPO
(Blue Card Network)

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET

This benefit booklet describes benefits provided under the Duke Energy Medical Plan Exclusive Provider Organization (EPO) option (the *Plan*). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. **Please read this benefit booklet carefully.**

The benefit plan described in this booklet is an employee health benefit plan, subject to the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Conditions, limitations and exclusions are set forth in this benefit booklet for easy reference.

In the event of a conflict between this benefit booklet and the terms in the *Plan* document, the *Plan* document will control.

Quick Reference - Toll Free Phone Numbers, Web Site and Addresses

BCBSNC Web Site www.bcbsnc.com/members/duke-energy	To find a network provider by location or specialty, get general benefit information, search through our corporate medical policies to see medical criteria used to administer your benefits, obtain claim forms, access information about all the Blue Extras℠ discounts, "proof of coverage" portability certificates and more.
Member Services Web Site www.bcbsnc.com/members/duke-energy	To enroll in a safe and secure customer service web site to: Check claim status, verify benefits and eligibility or request a new ID card.
BCBSNC Customer Service 1-888-554-3202 8 a.m-8 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new ID card requests.
Magellan Behavioral Health 1-800-359-2422	For mental health and substance abuse inpatient and outpatient pre-certification. Note: You do not need certification for office visits.
Blue Card® PPO Program 1-800-810-BLUE (2583)	To find a participating provider.
Medical Claims Filing: BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
Add/Remove Someone From Your Policy	Contact Duke Energy's myHR Service Center at 1-888-465-1300

Tips for Getting the Most Out of Your Health Care Benefits

1

Manage your out-of-pocket costs by managing the locations in which you receive care

Generally speaking, care received in a doctor's office is the most cost-effective for you, followed by hospital outpatient services. Hospital inpatient services often bear the highest cost. In addition, remember that in-network care (services from a BCBSNC participating provider who agrees to charge specified rates) will cost you less than similar care provided by an out-of-network provider. Know what your financial responsibility is before receiving care.

2

Pick a primary care physician

While our products do NOT require you to have a primary care physician, we strongly urge you to select and use one. A primary care physician informs you of your health care options, documents your care, and maintains your records for you. In addition, they save you time and unnecessary copayments by recommending appropriate specialists, coordinating your care with them, and informing them of things such as your medical history and potential drug interactions.

3

Understand your health care plan

The more you know about your benefits, the easier it will be to take control of your health. Let BCBSNC help you understand your plan and use it effectively through our customer-friendly Web site (**www.bcbsnc.com/members/duke-energy**), toll free Customer Service line (1-888-554-3202).

MEMBER RIGHTS AND RESPONSIBILITIES

As a Blue Cross and Blue Shield of North Carolina member, you have the right to:

- Receive, upon request, information about Blue Options including its services, doctors, a benefit booklet, benefit summary and directory of in-network providers
- Receive courteous service from BCBSNC
- Receive considerate and respectful care from your in-network providers
- Receive the reasons for BCBSNC's denial of a requested treatment or health care service, including (upon request) an explanation of the Utilization Management criteria and treatment protocol used to reach the decision
- Receive (upon request) information on the procedure and medical criteria used by BCBSNC to determine whether a procedure, treatment, facility, equipment, drug or device is investigational, experimental or requires prior approval
- Receive accurate, reader-friendly information to help you make informed decisions about your health care
- Participate actively in all decisions related to your health care
- Discuss all treatment options candidly with your health care provider regardless of cost or benefit coverage
- Expect that measures will be taken to ensure the confidentiality of your health care information
- File a grievance and expect a fair and efficient appeals process for resolving any differences you may have with BCBSNC
- Be treated with respect and recognition of your dignity and right to privacy
- Voice complaints or appeals about the organization or the care it provides
- Make recommendations regarding the organization's members' rights and responsibilities policies

As a Blue Cross and Blue Shield of North Carolina member, you have the responsibility to:

- Present your ID card each time you receive services
- Give your doctor permission to ask for medical records from other doctors you have seen. You will be asked to sign a transfer of medical records authorization form.
- Read your Blue Options benefit booklet and all other Blue Options member materials
- Call BCBSNC Customer Services if you have a question or do not understand the material provided by BCBSNC
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, tell your doctor.
- Provide complete information about any illness, accident or health care issues to BCBSNC and providers
- Make and keep appointments for non-emergency medical care. If it is necessary to cancel an appointment, give the doctor's office adequate notice.
- Participate in understanding your health problems and the medical decisions regarding your health care
- Be considerate and courteous to Blue Options providers, their staff and BCBSNC representatives
- Notify your employer and BCBSNC if you have any other group coverage
- Notify your group administrator of any changes regarding dependents and marital status
- Protect your ID card from unauthorized use.

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WELCOME TO BLUE OPTIONS

Welcome to Blue Cross and Blue Shield of North Carolina's Blue Options plan!

As a *member* of the Blue Options plan, you will enjoy quality health care from a network of health care *providers* and easy access to *in-network specialists*. There are no benefits for services from *out-of-network providers*. You may verify a North Carolina *provider's* participation by calling Customer Services at the number given in "Whom Do I Call?"

You may receive, upon request, information about Blue Options, its services and *doctors*, including this benefit booklet with a benefit summary, and a directory of *in-network providers*.

How To Use Your Blue Options Benefit Booklet

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. Please read it carefully.

If you are trying to determine whether coverage will be provided for a specific service, you may want to review all of the following:

- "Summary of Benefits" to get an overview of your specific benefits, such as *deductible*, *coinsurance* and maximum amounts
- "*Covered Services*" to get more detailed information about what is covered and what is excluded from coverage
- "*Utilization Management*" for important information about when *prior review* and *certification* are required
- "What Is Not Covered?" to see general exclusions from coverage.

If you still have questions, you can call BCBSNC Customer Services at the number listed on your *ID Card* or in "Whom Do I Call?" and get further information.

As you read this benefit booklet, keep in mind that any word you see in **italics *(italics)* is a defined term** and will appear in "Definitions" at the end of this benefit booklet.

You will also want to review the following sections of this benefit booklet:

- "How Blue Options Works" explains the coverage levels available to you
- "What If You Disagree With A Decision?" explains the rights available to you when BCBSNC makes a decision and you do not agree.

Notice For Non-English Speaking *Members*

This benefit booklet contains a summary in English of your rights and benefits under the *Plan*. If you have difficulty understanding any part of this benefit booklet, contact BCBSNC Customer Service to obtain assistance.

AVISO PARA *AFILIADOS* QUE NO HABLAN INGLES

Este manual de beneficios contiene un resumen en inglés de sus derechos y beneficios que le ofrece el *Plan*. Si usted tiene dificultad en entender alguna sección de este manual, por favor llame al BCBSNC Customer Service para recibir ayuda.

WHOM DO I CALL?

BCBSNC Web Site

To view your claims, get *Plan* information, claim forms, health and wellness information, find a *doctor*, change your address, and request new *ID cards*, visit the BCBSNC Web site: **www.bcbsnc.com/members/duke-energy**

BCBSNC Customer Service

For questions about your benefits or claims, *ID card* requests, or to voice a complaint:

BCBSNC Customer Service ..... 1-888-554-3202 (toll free)

Mental Health And Substance Abuse Services

Companies who have signed contracts with BCBSNC administer these benefits. You must contact these vendors directly and request *prior review* for *inpatient* and *outpatient* services, except for *office visit* services and in *emergencies*. In the case of an *emergency*, please notify the vendor as soon as reasonably possible:

Magellan Behavioral Health ..... 1-800-359-2422 (toll free)

HealthLine Blue SM

To receive confidential, up-to-date health information 24 hours a day from specially trained nurses:

HealthLine Blue ..... 1-877-477-2424 (toll free)

COBRA Administrator

UMR ..... 1-800-523-3578 (toll free)

Prior Review

Some services require *prior review* and *certification* by BCBSNC. The list of these services may change from time to time. Please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed above for current information about which services require *prior review*. See "Prospective Review/*Prior Review*" in "*Utilization Management*" for information about the review process. To request *prior review*, call:

Providers ..... 1-800-214-4844 (toll free)
Members ..... 1-877-258-3334 (toll free)

HOW BLUE OPTIONS WORKS

In-Network Benefits

In-network providers are health care professionals and facilities that have contracted with BCBSNC, or *providers* participating in the BlueCard PPO program. *In-network providers* agree to limit charges for *covered services* to the *allowed amount*. If the billed amount is greater than the *allowed amount*, you are not responsible for the difference. You pay only the applicable *copayment* or *coinsurance*, and noncovered expenses. Your *in-network provider* is required to use the Blue Options network *hospital* where he/she practices, unless that *hospital* cannot provide the services you need.

Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the Blue Options program. Your *ID card* tells participating *providers* that you are a *member* of BCBSNC. When you use a *provider* participating in the local Blue Cross or Blue Shield Plan's *provider* network, benefits are provided at the *in-network copayment* or *coinsurance*.

You are not required to obtain any referrals to see an *in-network provider*. *In-network providers* will file claims for you. It is the *member's* responsibility to request *prior review* when necessary. *Prior review* is not required for an *emergency*.

The list of *in-network providers* may change from time to time. *In-network providers* are listed on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" Please note that *dentists* and orthodontists do not participate in the *provider* network.

Out-Of-Network Benefits

There are no benefits for services from *out-of-network providers*.

Out-Of-Network Benefit Exceptions

In an *emergency*, in situations where *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, or in continuity of care situations, *out-of-network* benefits will be paid at your *in-network copayment* or *coinsurance* and will be based on the billed amount. However, you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement. If you are billed by the *provider*, you will be responsible for paying the bill and filing a claim with BCBSNC.

For more information, see "*Emergency* Care," "Continuity Of Care" in "*Utilization Management*," and for information about BCBSNC's access to care standards, see the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy**. If you believe an *in-network provider* is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an *out-of-network provider*.

The Role Of A *Primary Care Provider (PCP)* Or *Specialist*

It is important for you to maintain a relationship with a *PCP*, who will help you manage your health and help you make decisions about your health care. If you change *PCPs*, be sure to have your medical records transferred, especially immunization records, to provide your new *doctor* with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care *provider* regardless of cost or benefit coverage. *PCPs* are trained to deal with a broad range of health care issues and can help you to determine when you need a *specialist*.

Please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service to be sure the *provider* you choose is available to be a *PCP*. You may want to confirm that the *provider* is in the network before receiving care.

If your *PCP* or *specialist* leaves the BCBSNC *provider* network and they are currently treating you for an ongoing special condition, see "Continuity Of Care" in "*Utilization Management*."

Members with serious or chronic disabling or life-threatening conditions may be allowed to select the *specialist* treating this condition as their *PCP*. The selected *specialist* would be responsible for providing and coordinating the *member's* primary and specialty care. The selection of a *specialist* under these circumstances shall be made under a treatment plan approved by the *specialist*, and BCBSNC, with notice to the *PCP* if applicable. A request may be denied where it is determined that the *specialist* cannot appropriately coordinate the *member's* primary and specialty care. To make this request or if you would like the professional qualifications of your *PCP* or *in-network specialist*, you may call BCBSNC Customer Service at the number given in "Whom Do I Call?"

Carry Your *Identification Card*

Your *ID card* identifies you as a Blue Options *member*. If any information on your *ID card* is incorrect or if you need additional cards, please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC

HOW BLUE OPTIONS WORKS *(cont.)*

Customer Service at the number listed in "Whom Do I Call?" **Be sure to carry your *ID card* with you at all times and present it each time you seek health care.**

Making An Appointment

Call the *provider's* office and identify yourself as a Blue Options *member*. Please ask the receptionist whether the *provider's* office is *hospital*-owned or operated or provides *hospital*-based services. Your *medical services* may be covered under *Outpatient* Services benefit. Your *provider* directory will also help you make this determination. *Provider* directories are available through the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or by calling BCBSNC Customer Service at the number given in "Whom Do I Call?" If you need nonemergency services after your *provider's* office has closed, please call your *provider's* office for their recorded instructions. You may also contact the nurse advice line, HealthLine Blue, for assistance.

If you cannot keep an appointment, call the *provider's* office as soon as possible. Charges for missed appointments, which *providers* may require as part of their routine practice, are not covered.

HealthLine Blue

You may call a HealthLine Blue nurse to assist you with medical questions, offer support, and send you free videotapes and brochures on health topics appropriate for your condition. *Members* may ask to speak with the same nurse on an ongoing basis. You may also visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** to search a library of current health topics, send secure messages to the HealthLine Blue nurses, learn about symptoms and medications and use tools that guide you through important health care decisions. See the number listed in "Whom Do I Call?" to speak to a HealthLine Blue nurse.

How To File A Claim

In-network providers will file claims for you. When you file a claim, mail the completed claim form for all *medical services*, including mental health and substance abuse services, to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

COVERED SERVICES

Blue Options covers only those services that are *medically necessary*. Also keep in mind as you read this section:

- **Certain services require *prior review* and *certification* in order for you to avoid a partial (penalty) or complete denial of benefits. General categories of services are noted below as requiring *prior review*. Also see "Prospective Review/*Prior Review*" in "*Utilization Management*" for information about the review process, and visit the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or call BCBSNC Customer Service to ask whether a specific service requires *prior review* and *certification*.**
- Exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "*Covered Services*." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "*Covered Services*," "Summary Of Benefits" and "What Is Not Covered?"
- You may also receive, upon request, information on the procedure and medical criteria used by BCBSNC to determine whether a procedure, treatment, facility, equipment, drug or device is *medically necessary* and eligible for coverage, *investigational* or *experimental*, or requires *prior review* and *certification* by BCBSNC. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. If you need more information about BCBSNC medical policies, see the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy**, or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Office Services

Care you receive as part of an *office visit* or house call is covered with a *copayment*, except as otherwise noted in this benefit booklet. Some *providers* may receive items such as supplies or drugs from third parties. In these cases, you may be billed directly by the supplier. Benefit payments for these services will be based on the type of supplier and how the services are billed.

The *Plan* also provides benefits for six nutritional visits per *benefit period*. Your benefits cover a total of six visits to an *in-network provider*. If you see an *in-network provider*, any applicable *copayment*, or *coinsurance* is waived for these six visits.

A *copayment* will not apply if you only receive services, such as allergy shots or other injections, and are not charged for an *office visit*.

Certain diagnostic imaging procedures, such as CT scans and MRIs, are subject to *coinsurance* and any applicable *deductible*, and may require *prior review* and *certification* or services will not be covered.

Some *doctors* or *other providers* may practice in *outpatient clinics* or provide *hospital*-based services in their offices. These services are covered as *Outpatient* Services and are listed as *Outpatient Clinic* Services in "Summary Of Benefits." The *provider* search on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** indicates which *providers* will collect *deductible* and *coinsurance*, or you can call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for this information.

Office Services Exclusion

- Services in free-standing surgical facilities, independent laboratories, therapy facilities or *outpatient hospital* departments.

Preventive Care

The *Plan* covers *preventive care* services that can help you stay safe and healthy.

Routine Physical Examinations

One routine physical examination and related diagnostic services per *benefit period* will be covered for each *member* age two and older.

Well-Baby And Well-Child Care

These services are covered for each *member* up to 24 months of age including periodic assessments and immunizations. Benefits are limited to six well-baby visits for *members* through 12 months old and three well-child visits for *members* 13 months to 24 months old.

Immunizations

The full series of standard immunizations recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians (AAFP) is covered.

Covered immunizations include the following:

- Tetanus, diphtheria, pertussis (Td/Tdap)
- Polio
- HiB
- Hepatitis A and B

- Measles-Mumps-Rubella (MMR)
- Influenza
- Pneumococcal vaccine
- Shingles
- Meningococcal vaccine.
- Human papillomavirus vaccine
- Chicken pox
- Rotavirus

Immunizations Exclusions

- Immunizations required for occupational hazard
- Immunizations required for international travel.

Gynecological Exam And Cervical Cancer Screening

The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and *doctor's* interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papilloma virus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

Ovarian Cancer Screening

For female *members* age 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered. A female *member* is considered "at risk" if she:

- Has a family history with at least one first-degree relative with ovarian cancer; and a second relative, either first-degree or second-degree with breast, ovarian, or nonpolyposis colorectal cancer; or
- Tested positive for a hereditary ovarian cancer syndrome.

Screening Mammograms

Beginning at age 35, one screening mammogram will be covered per female *member* per calendar year, along with a *doctor's* interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a *doctor* when a female *member* is considered at risk for breast cancer.

A female *member* is "at risk" if she:

- Has a personal history of breast cancer
- Has a personal history of biopsy-proven benign breast disease
- Has a mother, sister, or daughter who has or has had breast cancer, or
- Has not given birth before the age of 30.

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic *member* who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer. Increased/high risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered *surgery,* such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as Hemoccult screenings.

The *provider* search on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** can help you find office-based *providers* or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for this information.

Prostate Screening

One prostate specific antigen (PSA) test or an equivalent serological test will be covered per male *member* per calendar year. Additional PSA tests will be covered if recommended by a *doctor.*

Diagnostic Services

Diagnostic procedures such as laboratory studies, radiology services and other diagnostic testing, which may include electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs), help your *doctor* find the cause and extent of your condition in order to plan for your care.

Certain diagnostic imaging procedures, such as CT scans and MRIs, may require *prior review* and *certification* or services will not be covered.

Your *doctor* may refer you to a freestanding radiology center for these procedures. Separate benefits for interpretation of diagnostic services by the attending *doctor* are not provided in addition to benefits for that *doctor's* medical or surgical services, except as otherwise determined by BCBSNC.

Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure. See "Summary Of Benefits."

Bone Mass Measurement Services

The *Plan* covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if *medically necessary*. Qualified individuals include *members* who have any one of the following conditions:

- Estrogen-deficient and at clinical risk of osteoporosis or low bone mass
- Radiographic osteopenia anywhere in the skeleton
- Receiving long-term glucocorticoid (steroid) therapy
- Primary hyperparathyroidism
- Being monitored to assess the response or effect of commonly accepted osteoporosis drug therapies
- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

See *Outpatient* Services in the "Summary Of Benefits."

Emergency Care

The *Plan* provides benefits for *emergency services*. An *emergency* is the sudden and unexpected onset of a condition of such severity 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 an individual, or with respect to a pregnant woman the health of the pregnant woman or her unborn child, in serious jeopardy
- Serious physical impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Death.

Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of *emergencies*.

What To Do In An *Emergency*

In an *emergency*, you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community emergency resources to obtain assistance in handling life-threatening *emergencies*. If you are unsure if your condition is an *emergency*, you can call HealthLine Blue; and a HealthLine Blue nurse will provide information and support that may save you an unnecessary trip to the emergency room.

Prior review is not required for *emergency services*. Your visit to the emergency room will be covered if your condition meets the definition of an *emergency*.

If you go to an emergency room for treatment of an *emergency*, your *coinsurance* will be the same, whether you use an *in-network* or *out-of-network provider*. When you receive these services from an *out-of-network provider*, benefits are based on the billed amount. However you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement, and you may be required to pay the entire bill at the time of service, and file a claim with BCBSNC.

Prior review and *certification* by BCBSNC are required for *inpatient* hospitalization and other selected services following *emergency services* (including screening and stabilization) in order to avoid a penalty. You may need to transfer to an *in-network hospital* once your condition has been *stabilized* in order to continue receiving *in-network* benefits.

Care Following *Emergency Services*

In order to receive *in-network* benefits for follow-up care related to the *emergency* (such as *office visits* or therapy once you left the emergency room or were discharged from the *hospital*), you must use *in-network providers*. Follow-up care related to the *emergency* condition is not considered an *emergency* and will be treated the same as a normal health care benefit.

Urgent Care

The *Plan* also provides benefits for *urgent care* services. When you need *urgent care*, call your *PCP*, a *specialist* or go to an *urgent care provider*. If you are not sure if your condition requires *urgent care*, you can call HealthLine Blue.

Urgent care includes services provided for a condition that occurs suddenly and unexpectedly and requires prompt diagnosis or treatment such that, in the absence of immediate care, the *member* could reasonably be expected to suffer chronic illness, prolonged impairment or the need for more serious treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female *members*. A *copayment* may apply for the *office visit* to diagnose pregnancy. If a *member* changes *providers* during pregnancy, terminates coverage during pregnancy, or the pregnancy does not result in delivery, one or more *copayments* may be charged for pre-natal services depending upon how the services are billed by the *provider*.

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 *doctor*, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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*.

If the mother chooses a shorter stay, coverage is available for a *home health* visit for post-delivery follow-up care if received within 72 hours of discharge. In order to avoid a penalty, *prior review* and *certification* are required for *inpatient* stays extending beyond 48 hours following a vaginal delivery or 96 hours following a cesarean section. For information on *certification*, contact BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Termination of Pregnancy (Therapeutic Abortion)

Benefits for therapeutic abortion are available through the first 16 weeks of pregnancy for all female *members*.

Complications Of Pregnancy

Benefits for *complications of pregnancy* are available to all female *members* including dependent children. Please see "Definitions" for an explanation of *complications of pregnancy*.

Newborn Care

Inpatient newborn care of a well baby is covered under the mother's maternity benefits described above only during the first 48 hours after a vaginal delivery or 96 hours after delivery by cesarean section. This *inpatient* newborn care (well baby) requires only one admission *copayment* or *benefit period deductible* for both mother and baby. Benefits also include newborn hearing screening ordered by a *doctor* to determine the presence of permanent hearing loss.

For additional coverage of the newborn, whether *inpatient* (sick baby) or *outpatient*, the newborn must be enrolled for coverage as a dependent child within 31 days of the birth. At this time, the baby must meet the individual *benefit period deductible* if applicable, and *prior review* and *certification* are required to avoid a penalty.

Infertility And *Sexual Dysfunction* Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of *infertility* and *sexual dysfunction* for all *members* except dependent children.

Sterilization

This benefit is available for all *members* except dependent children. Sterilization includes female tubal ligation and male vasectomy.

Family Planning Exclusions

- The collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
- Artificial means of conception, including, but not limited to, artificial insemination, in-vitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm insemination (ICSI), and gamete intrafallopian tube placement (GIFT) and associated services
- Donor eggs and sperm
- Surrogate mothers
- Care or treatment of the following:
  - termination of pregnancy
  - contraceptive devices
  - reversal of sterilization
  - *infertility* and *sexual dysfunction* for dependent children.
- Elective abortion
- Treatment for *infertility* or reduced fertility that results from a prior sterilization procedure or when *infertility* or reduced fertility is the result of a normal physiological change such as menopause.

Facility Services

- *Outpatient* services received in a *hospital*, a *hospital*-based facility or an *outpatient clinic*.
- *Inpatient hospital* services. If you are admitted before the *effective date*, benefits will not be available for services received prior to the *effective date*. *Prior review* must be requested and *certification* must be obtained in advance from BCBSNC to avoid a penalty, except for maternity deliveries and *emergencies*. See "Maternity Care" and "*Emergency* Care."
- Surgical services received in an *ambulatory surgical center*
- *Covered services* received in a *skilled nursing facility*. *Prior review* must be requested and *certification* must be obtained in advance from BCBSNC to avoid a penalty. *Skilled nursing facility* services are limited to a day maximum per *benefit period*. See "Summary Of Benefits."

Other Services

Ambulance Services

The *Plan* covers services in a ground *ambulance* traveling:

- From a *member's* home or scene of an accident or *emergency* to a *hospital*
- Between *hospitals*
- Between a *hospital* and a *skilled nursing facility*

when such a facility is the closest one that can provide *covered services* appropriate to your condition. Benefits may also be provided for *ambulance* services from a *hospital* or *skilled nursing facility* to a *member's* home when *medically necessary*.

The *Plan* covers services in an air *ambulance* traveling from the site of an *emergency* to a *hospital* when such a facility is the closest one that can provide *covered services* appropriate to your condition and ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land. Nonemergency air *ambulance* services require *prior review* and *certification* or services will not be covered.

Ambulance Service Exclusion

- No benefits are provided primarily for the convenience of travel.

Blood

The *Plan* covers the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a *member's* own blood only when it is stored and used for a previously scheduled procedure.

Blood Exclusion

- Charges for the collection or obtainment of blood or blood products from a blood donor, including the *member* in the case of autologous blood donation.

Clinical Trials

The *Plan* provides benefits for participation in clinical trials phases II, III, and IV. Coverage is provided only for *medically necessary* costs of health care services associated with the trials, and only to the extent such costs

have not been or are not funded by other resources. The *member* must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of a life-threatening medical condition with services that are medically indicated and preferable for that *member* compared to non-*investigational* alternatives. In addition, the trial must:

- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical specialists
- Be approved by centers or groups funded by the National Institutes of Health, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

Clinical Trials Exclusions

- Clinical trials phase 1
- Non-health care services, such as services provided for data collection and analysis
- *Investigational* drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

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:

- Accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- *Congenital* deformity, including cleft lip and cleft palate
- Disease due to infection or tumor, including tumors, cysts and exostosis
- Temporomandibular joint (TMJ) disease, including splinting and use of intra-oral *prosthetic appliances* to reposition the bones. Surgical benefits for TMJ disease are limited to *surgery* performed on the temporomandibular joint. If TMJ is caused by malocclusion, then benefits are provided for surgical correction of malocclusion if surgical management of the TMJ is *medically necessary*. Please have your *provider* contact BCBSNC before receiving treatment for TMJ.
- Impacted wisdom teeth.

The *Plan* provides benefits for extractions, crowns, bridges, and dentures for treatment of disease due to infection or tumor. For treatment of *congenital* deformity including cleft lip and cleft palate, benefits may be provided for dentures and orthodontic braces used to treat the condition.

When any of the conditions listed above require surgical correction, benefits for *surgery* will be subject to *medical necessity* 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*. *Prior review* and *certification* are required or services will not be covered, unless treatment is for an *emergency*.

Dental Treatment Excluded Under Your Medical Benefit

- Injury related to chewing or biting
- Preventive dental care, diagnosis or treatment of or related to the teeth or gums
- For disease due to infection or tumor:
  - Dental implants
  - Treatment for periodontal disease
  - Dental root form implants or root canals
  - Orthodontic braces
- For TMJ disease:
  - Dental implants
  - Treatment for periodontal disease

- Dental root form implants or root canals
- Crowns and bridges
- Extractions
- Dentures
- Orthodontic braces

- Replacement of crowns, bridges, dentures or in-mouth appliances, except as specifically stated as covered.

Durable Medical Equipment

Benefits are provided for *durable medical equipment* and supplies required for operation of equipment when prescribed by a *doctor*. Equipment may be purchased or rented at the discretion of the *Plan*. The *Plan* provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer *medically necessary*. Certain *durable medical equipment* requires *prior review* and *certification* or services will not be covered.

Durable Medical Equipment Exclusions

- Appliances that serve no medical purpose or that are primarily for comfort or convenience
- Repair or replacement of equipment due to abuse or desire for new equipment
- Rental or purchase of wheelchairs, hospital type beds, oxygen equipment (including oxygen), insulin pumps, Glucowatch and Autosensors, nebulizers and supplies related to the use of nebulizers and other *durable medical equipment*, subject to the following:
  - The equipment must be prescribed by a physician and needed in the treatment of an illness or injury and will be provided on a rental basis for the period of treatment. At our option, such equipment may be purchased. If the equipment is purchased, benefits will be payable for subsequent repairs necessary to restore the equipment to a serviceable condition; subsequent repairs due to abuse or misuse, as determined by BCBSNC, are not covered;
  - Benefits will be limited to the standard models, as determined by BCBSNC;
  - The *Plan* will pay benefits, if determined to be *medically necessary*, for ONE of the following: a manual wheelchair, a motorized wheelchair, or motorized scooter.

BCBSNC will pay benefits for the replacement of any *durable medical equipment* subject to the proof of change in a medical condition or that the equipment is no longer usable or repairable.

Eye Exams

The *Plan* provides coverage for one routine comprehensive eye examination per *benefit period*. Diagnosis and treatment of medical conditions of the eye, and drugs administered for purposes other than for a visual examination, are not considered to be part of a routine eye exam and are subject to the benefits, limitations and exclusions of the *Plan*.

Eye Exams Exclusion

- Fitting for contact lenses, glasses or other hardware.

Home Health Care

Home health care services, such as professional services of a *registered nurse (RN)* or *licensed practical nurse (LPN)* for visits totaling 8 hours a day, are covered by the *Plan* when the *member* is *homebound* due to illness or injury. *Home health* care requires *prior review* and *certification* or services will not be covered.

Home Health Care Exclusions

- Homemaker services, such as cooking and housekeeping
- Dietitian services or meals
- Services that are provided by a close relative or a member of your household.

Home Infusion Therapy Services

Home infusion therapy is covered for the administration of *prescription drugs* directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a *doctor*. These services must be provided under the supervision of an *RN* or *LPN*. Home infusion therapy requires *prior review* and *certification* or services will not be covered.

Hospice Services

- Your coverage provides benefits for *hospice* services for care of a terminally ill *member* with a life expectancy of six months or less. Services are covered only as part of a licensed health care program centrally coordinated through an interdisciplinary team directed by a *doctor* that provides an integrated set

of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families.

Hospice Services Exclusion

- Homemaker services, such as cooking, housekeeping, food or meals.

Medical Supplies

Coverage is provided for *medical supplies* such as ostomy supplies, catheters, oxygen and diabetic pump and pump supplies (needles, syringes, teststrips are covered under the pharmacy plan). To obtain *medical supplies*/equipment, please find a *provider* on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service.

Medical Supplies Exclusion

- *Medical supplies* not ordered by a *doctor* for treatment of a specific diagnosis or procedure.

Orthotic Devices

Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part, are covered if *medically necessary* and prescribed by a *provider*. Foot orthotics may be covered only when custom molded to the patient. Charges for custom built orthopedic shoes when *medically necessary* must be prescribed by a *doctor* and limited to two (2) pairs per calendar year. Orthotic devices for correction of *positional plagiocephaly*, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, are subject to a benefit limit.

Orthotic Devices Exclusions

- Pre-molded foot orthotics
- Over-the-counter supportive devices.

Private Duty Nursing

The *Plan* provides benefits for *medically necessary* private duty services of an *RN* or *LPN* when ordered by your *doctor*. *Prior review* must be requested and *certification* must be obtained or services will not be covered. These services are always subject to the *deductible* and *coinsurance*, regardless of location of service.

Private Duty Nursing Exclusion

- Services provided by a close relative or a member of your household.

Prosthetic Appliances

The *Plan* provides benefits for the purchase, fitting, adjustments, repairs, and replacement of *prosthetic appliances*. The *prosthetic appliances* must replace all or part of a body part or its function. The type of *prosthetic appliance* will be based on the functional level of the *member*. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a prescription change after cataract *surgery*. Certain *prosthetic appliances* require *prior review* and *certification* or services will not be covered.

Prosthetic Appliances Exclusions

- Dental appliances except when *medically necessary* for the treatment of temporomandibular joint disease
- *Cosmetic* improvements, such as implantation of hair follicles and skin tone enhancements
- Lenses for keratoconus or any other eye procedure except as specifically covered under the *Plan*.

Surgical Benefits

Surgical benefits by a professional or facility *provider* on an *inpatient* or *outpatient* basis, including pre-operative and post-operative care and care of complications, are covered. Surgical benefits include diagnostic *surgery*, such as biopsies, sigmoidoscopies and colonoscopies, and reconstructive *surgery* performed to correct *congenital* defects that result in functional impairment of newborn, adoptive and foster children.

Certain surgical procedures, including those that are potentially *cosmetic*, require *prior review* and *certification* or services will not be covered.

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter, may not be eligible for separate reimbursement. For information about coverage of multiple surgical procedures, please refer to BCBSNC's medical policies, which are on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy**, or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Anesthesia

Your anesthesia benefit includes coverage for general, spinal block or monitored regional anesthesia ordered by the attending *doctor* and administered by or under the supervision of a *doctor* other than the attending surgeon or assistant at *surgery*. Separate benefits are not available for related services. Your coverage does not provide additional benefits for local anesthetics, which are covered as part of your surgical benefit.

Mastectomy Benefits

Under the Women's Health and Cancer Rights Act of 1998, the *Plan* provides for the following services related to mastectomy *surgery*:

- Reconstruction of the breast on which the mastectomy has been performed
- *Surgery* and reconstruction of the nondiseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive *surgery*
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Please note that the decision to discharge the patient following mastectomy *surgery* is made by the attending physician in consultation with the patient.

The benefits described above are subject to the same *deductibles, copayment* or *coinsurance* and limitations as applied to other medical and surgical benefits provided under the *Plan*.

Therapies

The *Plan* provides coverage for the following therapy services to promote the recovery of a *member* from an illness, disease or injury. A *doctor* or *other professional provider* must order these services.

Short-Term Rehabilitative Therapies

The following therapies are covered only for treatment of conditions that are expected to result in significant clinical improvement in a *member's* condition:

- Occupational therapy and/or physical therapy
- Speech therapy.

Benefits are limited to a visit maximum for occupational and/or physical therapy, speech therapy, chiropractic or any combination of these therapies. These visit limits apply in all places of service except *inpatient* (e.g., *outpatient*, office and home) regardless of the type of *provider* (chiropractors, other *doctors*, physical therapists). *Short-term rehabilitative therapy* received while an *inpatient* is not included in the *benefit period maximum*.

Other Therapies

The *Plan* covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Chemotherapy, including intravenous chemotherapy. For bone marrow or peripheral blood stem cell *transplants*, see "*Transplants*."

- Radiation therapy (including accelerated partial breast radiotherapy (breast brachytherapy). Breast brachytherapy is *investigational* but will be covered upon *prior review* and *certification*, based on meeting the American Society of Breast Surgeons (ASBS) criteria.)
- Limited treatment of autism, consisting of:

  (A) Therapy to develop interactive skills and skills necessary to perform the significant activities of daily living (eating, dressing, walking, bathing, toileting, and communicating). (The therapy must be performed by a licensed medical provider approved in advance. This therapy is not intended for schooling of an individual, even if the schooling requires a special environment. The provider must submit a treatment plan including the type of therapy to be administered, the goals, setting and periodic measures for the therapy, who will administer the therapy, and the patient's current ability to perform the desired results of the therapy. The treatment plan must be approved in advance by the Claims Administrator and updated quarterly with a report on the patient's condition, progress and future treatment plans.)

  (B) Care provided in accordance with the approved treatment plan by a non-licensed medical provider who is not a member of the patient's family, if the provider has been specifically trained to interact with the autistic patient and certified by a licensed medical provider as capable of working with the child. (This benefit is payable up to $50,000 during the lifetime of the patient, for the specific diagnosis of autism.)

  (C) Training and educational services provided by licensed medical providers (or non-licensed providers as described above) under an approved treatment plan for the parents or legal guardian of an autistic individual to teach the principles and practical applications of behavior modification (This benefit is payable up to $5,000 during the lifetime of the patient.)

Therapy Exclusions

- Cognitive therapy
- Speech therapy for stammering or stuttering.

Transplants

The *Plan* provides benefits for *transplants*, including *hospital* and professional services for covered *transplant* procedures. The *Plan* provides care management for *transplant* services and will help you find a *hospital* or Blue Quality Center for Transplants that provides the *transplant* services required. Travel and lodging expenses may be reimbursed, based on BCBSNC guidelines that are available upon request from a *transplant* coordinator.

For a list of covered transplants, call BCBSNC Customer Service at the number listed in "Whom Do I Call?" to speak with a *transplant* coordinator and request *prior review*. *Certification* must be obtained in advance from BCBSNC for all *transplant*-related services in order to assure coverage of these services.

If a *transplant* is provided from a living donor to the recipient *member* who will receive the *transplant*:

- Benefits are provided for reasonable and necessary services related to the search for a donor up to a maximum of $10,000 per *transplant*. However, other costs related to evaluation and procurement are covered up to the recipient *member's* coverage limit.
- Both the recipient and the donor are entitled to benefits of this coverage when the recipient is a *member*. Benefits provided to the donor will be charged against the recipient's coverage, if they don't have coverage for same elsewhere.

Some *transplant* services are *investigational* and not covered for some or all conditions or illnesses. Please see "Definitions" for an explanation of *investigational*.

***Transplants* Exclusions**

- The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient *member*
- The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a *member*
- *Transplants*, including high dose chemotherapy, considered *experimental* or *investigational*
- Services for or related to the transplantation of animal or artificial organs or tissues.

Mental Health And Substance Abuse Services

The *Plan* provides benefits for the treatment by a of *mental illness* and substance abuse by a *hospital, doctor* or *other provider*. Your coverage for *in-network inpatient* and *outpatient* services is coordinated through Magellan Behavioral Health.

Separate visit limits and benefit maximums may apply. See information on *office visit* benefit maximums below.

Office Visit Services

Prior review by Magellan Behavioral Health is not required for *office visit* services. The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- *Medically necessary* biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

The following rules apply to mental health *office visit* benefit maximums:

- Each service provided by a mental health *provider* will count as one visit
- Any mental health therapy services provided by a non-mental health *provider* during the course of an *office visit* will count as one visit.

Outpatient Services

Covered *outpatient* services when provided in a mental health or substance abuse treatment facility include:

- Each service listed in this section under *office visit* services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).

Inpatient Services

Covered *inpatient* treatment services also include:

- Each service listed in this section under *office visit* services
- Semi-private room and board
- Detoxification to treat substance abuse.

Please note benefits for *inpatient* and *outpatient medical care* are limited to one visit per day.

How To Access Mental Health And Substance Abuse Services

Prior review by Magellan Behavioral Health is not required for *office visit* services. Although *prior review* is not required for *emergency* situations, please notify Magellan Behavioral Health of your *inpatient* admission as soon as reasonably possible. When you need *inpatient* or *outpatient* treatment, call a Magellan Behavioral Health customer service representative at the number listed in "Whom Do I Call?" The Magellan Behavioral Health customer service representative will refer you to an appropriate *in-network provider* and give you information about *prior review* and *certification* requirements.

Mental Health And Substance Abuse Services Exclusions And Limitations

- Psychoanalysis
- Counseling with relatives about a patient with *mental illness*, alcoholism, drug addiction or chemical dependency
- *Inpatient* confinements that are primarily intended as a change of environment
- Mental health services received in residential treatment facilities.

WHAT IS NOT COVERED?

Exclusions for a specific type of service are stated along with the benefit description in "*Covered Services.*" Exclusions that apply to many services are listed in this section. To understand all of the exclusions that apply, read "*Covered Services,*" "Summary Of Benefits" and "What Is Not Covered?" In addition, the *Plan* does not cover services, supplies, drugs or charges for:

- Provided by *out-of-network providers,* except when approved in advance by BCBSNC or in an *emergency* or *urgent care* situation
- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under the *Plan*
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- A dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group
- Dates of service received prior to the *member's effective date*
- A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet.

A

Acupuncture and acupressure, unless services are provided by a medical *doctor*

Administrative charges billed by a *provider*, including charges for telephone consultations, failure to keep a scheduled visit, completion of claim forms, obtaining medical records, and late payments

Costs in excess of the ***allowed amount*** for services usually provided by one *doctor*, when those services are provided by multiple *doctors* or *medical care* provided by more than one *doctor* for treatment of the same condition

C

Claims not submitted to BCBSNC within 18 months of the date the charge was *incurred*, except in the absence of legal capacity of the *member*

Contraceptives, including oral and injectable contraceptives, contraceptive devices and long-term reversible contraceptives including, but not limited to, intrauterine devices and implanted hormonal contraceptives, solely prescribed for the purpose of contraception. These services are excluded at the request of your *employer.*

Convenience items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items

Cosmetic services, which include removal of excess skin from the abdomen, arms or thighs, and *surgery* for psychological or emotional reasons, except as specifically covered by the *Plan*

Services received either before or after the **coverage period** of the *Plan*, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination

Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor.*

D

Dental services provided in a *hospital*, except as specifically covered by the *Plan*, when a hazardous condition exists at the same time, or covered oral *surgery* services are required at the same time as a result of a bodily injury. Dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by the *Plan.*

The following **drugs:**

- *Prescription drugs* except as specifically covered by the *Plan*
- Injections by a health care professional of injectable *prescription drugs* which can be self-administered, unless medical supervision is required
- Clomiphene (e.g., Clomid), menotropins (e.g., Repronex) or other drugs associated with conception by artificial means

WHAT IS NOT COVERED? *(cont.)*

- *Experimental* drugs or any drug not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to *prescription drugs* used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been approved as effective in any one of the three nationally recognized drug reference guides:
    1. The American Medical Association Drug Evaluations
    2. The American Hospital Formulary Service Drug Information
    3. The United States Pharmacopoeia Drug Information.

E

Services primarily for **educational** purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by the *Plan*

Side effects and complications of noncovered services, except for *emergency services* in the case of an ***emergency***

Services that would not be necessary if a noncovered service had not been received, except for *emergency services* in the case of an ***emergency***

The following **equipment**:

- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, pool or memberships to health clubs.

Experimental services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service, except as specifically covered by the *Plan*

F

*Routine **foot care*** that is palliative or *cosmetic*

G

Genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing

H

Hearing aids or examinations for the fitting of hearing aids except as specifically covered by the *Plan*

***Holistic** medicine* services

Hypnosis except when used for control of acute or chronic pain

I

Inpatient **admissions** primarily for the purpose of receiving diagnostic services or a physical examination. *Inpatient* admissions primarily for the purpose of receiving therapy services, except when the admission is a continuation of treatment following care at an *inpatient* facility for an illness or accident requiring therapy.

Investigational services in nature or obsolete, including any service, drugs, procedure or treatment directly related to an *investigational* treatment, except as specifically covered by the *Plan*

L

Services provided and billed by a **lactation consultant**

M

Services or supplies deemed not ***medically necessary***

O

Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a *member* or for treatment of **obesity**, except for surgical treatment of morbid obesity, or as specifically covered by the *Plan*

P

Care or services from a ***provider*** who:

- Cannot legally provide or legally charge for the services or services are outside the scope of the *provider's* license or certification

- Provides and bills for services from a licensed health care professional who is in training
- Is in a *member's* immediate family.

R

The following **residential care** services:

- Care in a self-care unit, apartment or similar facility operated by or connected with a *hospital*
- Domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities, except for substance abuse treatment, or any similar facility or institution.

Respite care except as specifically covered by the *Plan*

S

Services or supplies that are:

- Not performed by or upon the direction of a *doctor* or *other provider*
- Available to a *member* without charge.

Treatment or studies leading to or in connection with **sex changes or modifications** and related care

Sexual dysfunction unrelated to organic disease

Shoe lifts and shoes of any type unless part of a brace

T

The following types of **therapy**:

- Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
- *Maintenance therapy*
- Massage therapy.

Travel, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the *Plan*

V

The following **vision** services:

- Radial keratotomy and other refractive eye *surgery*, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
- Eyeglasses or contact lenses, except as specifically covered in "*Prosthetic Appliances*"
- Orthoptics, vision training, and low vision aids.

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind except for external nutrition administered exclusively via tube feeding as the sole source of nutrition. External nutrition products that are administered orally are excluded.

UTILIZATION MANAGEMENT

To make sure you have access to high quality, cost-effective health care, the *Plan* has a *utilization management* (*UM*) program. The *UM* program requires that certain health care services be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are *medically necessary*, provided in the proper setting and for a reasonable length of time. **The *Plan* will honor a *certification* to cover *medical services* or supplies under the *Plan* unless the *certification* was based on a material misrepresentation about your health condition or you were not eligible for these services under the *Plan* due to termination of coverage or nonpayment of premiums.**

Rights And Responsibilities Under The *UM* Program

Your *Member* Rights

Under the *UM* program, you have the right to:

- A *UM* decision that is timely, meeting applicable federal time frames
- The reasons for BCBSNC's denial of a requested treatment or health care service, including an explanation of the *UM* criteria and treatment protocol used to reach the decision
- Have a medical director from BCBSNC make a review of all denials of service that were based upon *medical necessity*
- Request a review of denial of benefit coverage through the *grievance* process
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf.

An authorized representative may act on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under the "*Utilization Management*" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

BCBSNC's Responsibilities

As part of all *UM* decisions, BCBSNC will:

- Provide you and your *provider* with a toll-free telephone number to call *UM* review staff when *certification* of a health care service is needed
- Limit what BCBSNC requests from you or your *provider* to information that is needed to review the service in question
- Request all information necessary to make the *UM* decision, including pertinent clinical information
- Provide you and your *provider* prompt notification of the *UM* decision consistent with the *Plan*.

In the event BCBSNC does not receive sufficient information to approve coverage for a health care service within specified time frames, BCBSNC will notify you in writing that benefit coverage has been denied. The notice will explain how you may pursue a review of the *UM* decision.

Prospective Review/*Prior Review*

The *Plan* requires that certain health care services receive *prior review* as noted in "*Covered Services*." These types of reviews are called prospective reviews. **If neither you nor your *provider* requests *prior review* and receives *certification*, this may result in a partial or complete denial of benefits. General categories of services with this requirement are noted in "*Covered Services*." You may also visit the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for a detailed list of these services. The list of services that require *prior review* may change from time to time.**

If the requested *certification* is denied, you have the right to appeal. See "What If You Disagree With A Decision?" for additional information. Certain services may not be covered *out-of-network*. See "*Covered Services*."

BCBSNC will make a decision on your request for *certification* within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated within three business days after BCBSNC receives all necessary information but no later than 15 days from the date BCBSNC received the request. If your request is incomplete, then within five days from the date BCBSNC received your request, BCBSNC will notify you and your *provider* of how to properly complete your request. BCBSNC may also take an extension of up to 15 days if additional information is needed. BCBSNC will notify you and your *provider* before the end of the initial 15-day period of the information needed and the date by which BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a decision within three business days. If BCBSNC does not approve benefit coverage of a health care service, BCBSNC will notify you and the *provider* by written or electronic confirmation.

Expedited Prospective Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. BCBSNC will notify you and your *provider* of its decision as soon as possible, taking into account the medical circumstances. BCBSNC will notify you and your *provider* of its decision within 72 hours after receiving the request. If BCBSNC needs additional information to process your expedited review, BCBSNC will notify you and your *provider* of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the time period specified for you to provide the information, whichever

is earlier, BCBSNC will make a decision on your request within a reasonable time but no later than 48 hours. An expedited review may be requested by callingBCBSNC Customer Service at the number given in "Whom Do I Call?"

Concurrent Reviews

BCBSNC will also review health care services at the time you receive them. These types of reviews are concurrent reviews.

BCBSNC will communicate concurrent review decisions to the *hospital* or other facility within three business days after BCBSNC receives all necessary information but no later than 15 days after the request. If BCBSNC does not provide *certification* of a health care service, BCBSNC will notify you, your *hospital's* or other facility's *UM* department and your *provider*. Written confirmation of the decision will also be sent to your home by U.S. mail.

For concurrent reviews, the *Plan* will remain responsible for *covered services* you are receiving until you or your representatives have been notified of the denial of benefit coverage.

Expedited Concurrent Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. If you request an extension of treatment that BCBSNC has already approved at least 24 hours before the current approved treatment ends, BCBSNC will notify you and your *provider* of its decision as soon as possible taking into account the medical circumstances, but no later than 24 hours after receiving the request.

Retrospective Reviews

BCBSNC also reviews the coverage of health care services after you receive them (retrospective reviews). Retrospective review may include a review to determine if services received in an emergency setting qualify as an *emergency*. BCBSNC will make all retrospective review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date BCBSNC received the request. When the decision is to deny benefit coverage, BCBSNC will notify you and your *provider* in writing within five business days of the decision. All decisions will be based on *medical necessity* and whether the service received was a benefit under this *Plan*. BCBSNC may take an extension of up to 15 days if additional information is needed. Before the end of the initial 30-day period, BCBSNC will notify you of the extension, the information needed and the date by which BCBSNC expects to make a decision. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days. Services that were approved in advance by BCBSNC will not be subject to denial for *medical necessity* once the claim is received, **unless the *certification* was based on a material misrepresentation about your health condition or you were not eligible for these services under the *Plan* due to termination of coverage or nonpayment of premiums**. All other services may be subject to retrospective review and could be denied for *medical necessity* or for a benefit limitation or exclusion.

Care Management

Members with complicated and/or chronic medical needs may, solely at the option of BCBSNC, be eligible for care management services. Care management (or case management) encourages *members* with complicated or chronic medical needs, their *providers*, and the *Plan*, to work together to meet the individual's health needs and promote quality outcomes. To accomplish this, *members* enrolled in or eligible for care management programs may be contacted by BCBSNC or by a representative of BCBSNC. The *Plan* is not obligated to provide the same benefits or services to a *member* at a later date or to any other *member*. Information about these services can be obtained by contacting an *in-network PCP* or *in-network specialist* or by calling BCBSNC Customer Service.

Continuity Of Care

Continuity of care is a process that allows *members* with ongoing special conditions to continue receiving care from an *out-of-network provider*, when the *member's employer* changes plans or when their *provider* is no longer in the Blue Options network. If your *PCP* or *specialist* leaves the BCBSNC *provider* network and they are currently treating you for an ongoing special condition that meets BCBSNC continuity of care criteria, BCBSNC will notify you 30 days before the *provider's* termination, as long as BCBSNC receives timely notification from the *provider*. To be eligible for continuity of care, the *member* must be actively being seen by the *out-of-network provider* for an ongoing special condition and the *provider* must agree to abide by the *Plan's* requirements for continuity of care. An ongoing special condition means:

- in the case of an acute illness, a condition that is serious enough to require *medical care* or treatment to avoid a reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires *medical care* or treatment over a prolonged period of time;
- in the case of pregnancy, the second and third trimesters of pregnancy;
- in the case of a terminal illness, an individual has a medical prognosis that the *member's* life expectancy is six months or less.

The allowed transitional period shall extend up to 90 days, as determined by the *provider*, except in the cases of:

- scheduled *surgery*, organ transplantation, or *inpatient* care which shall extend through the date of discharge and post-discharge follow-up care or other *inpatient* care occurring within 90 days of the date of discharge; and

UTILIZATION MANAGEMENT (cont.)

- second trimester pregnancy which shall extend through the provision of 60 days of postpartum care; and
- terminal illness which shall extend through the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be paid at the *member's in-network* benefit level. Continuity of care will not be provided when the *provider's* contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal. Please call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for additional information.

Further Review Of *Utilization Management* Decisions

If you receive a *noncertification* as part of the *prior review* process, you have the right to request that the *Plan* review the decision through the *grievance* process. Refer to "What If You Disagree With A Decision?"

Delegated *Utilization Management*

For *UM* and the first level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services, Magellan Behavioral Health is responsible. Claims determinations and second level *grievance* review are provided by BCBSNC.

Evaluating New Technology

In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new medical technology, procedures and equipment. These policies allow BCBSNC to determine the best services and products to offer *members*. They also help BCBSNC keep pace with the ever-advancing medical field. Before implementing any new or revised policies, BCBSNC reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. BCBSNC then seeks additional input from *providers* who know the needs of the patients they serve.

WHAT IF YOU DISAGREE WITH A DECISION?

In addition to the *UM* program, the *Plan* offers a *grievance* procedure for *members*. *Grievances* include dissatisfaction with a claims denial or any decisions (including an appeal of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services. If you have a *grievance*, you have the right to request that BCBSNC review the decision through the *grievance* process. The *grievance* process is voluntary and may be requested by the *member* or an authorized representative acting on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps To Follow In The *Grievance* Process

For each step in this process, there are specified time frames for filing a *grievance* and for notifying you or your *provider* of the decision. The review must be requested in writing, within 180 days of a denial of benefit coverage (the initial claim denial or the first level *grievance* review decision).

Any request for review should include:

- Employee's ID number
- Employee's name
- Any other information that may be helpful for the review.
- Patient's name
- The nature of the *grievance*

To request a form to submit a request for review, visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

All correspondence related to a request for a review through BCBSNC's *grievance* process should be sent to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

In addition, members may also receive assistance with *grievances* from the Managed Care Patient Assistance Program by contacting:

Managed Care Patient Assistance Program
9001 Mail Service Center
Raleigh, NC 27699-9001
Tel: (919) 733-6272
Tel (toll free in NC): 1-866-867-6272
Email: MCPA@ncdoj.gov

Following such request for review, a review will be conducted by BCBSNC, by someone who is neither the individual who made the original claims denial that is the subject of the *grievance*, nor the subordinate of such individual. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations with respect to whether a particular treatment, drug or other item is *experimental, investigational*, or not *medically necessary* or appropriate, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

First Level Grievance Review

BCBSNC will provide you with the name, address and phone number of the *grievance* coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials. For *grievances* concerning quality of health care, an acknowledgement will be sent by BCBSNC within five business days.

Although you are not allowed to attend a first level *grievance* review, BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level *Grievance* Review

Since the *Plan* is subject to *ERISA*, the first level *grievance* review is the only level that you must complete before you can pursue your *grievance* in an action in federal court.

Otherwise, if you are dissatisfied with the first level *grievance* review decision, you have the right to a second level *grievance* review. Second level *grievances* are not allowed for benefits or services that are clearly excluded by this benefit booklet or quality of care complaints. Within ten business days after BCBSNC receives your request for a second level *grievance* review, the following information will be given to you:

- Name, address and telephone number of the *grievance* coordinator
- A statement of your rights, including the right to:

WHAT IF YOU DISAGREE WITH A DECISION? *(cont.)*

- request and receive from BCBSNC all information that applies to your case
- attend the second level *grievance* review meeting
- present your case to the review panel
- submit supporting material before and at the review meeting
- ask questions of any member of the review panel
- be assisted or represented by a person of your choosing, including a family member, an *employer* representative, or an attorney
- pursue other voluntary alternative dispute resolution options.

The second level review meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level *grievance* review request. You will receive notice of the meeting date and location at least 15 days before the meeting. You have the right to a full review of your *grievance* even if you do not attend the meeting. A written decision will be issued to you within five business days of the review meeting.

Notice Of Decision

If any claim (whether expedited or nonexpedited) shall be wholly or partially denied at either the first level *grievance* or the second level *grievance* review, a written notice shall be provided to the *member* worded in an understandable manner and shall set forth:

- The specific reason(s) for the denial
- Reference to the specific the *Plan* provisions on which the decision is based
- A statement that the *member* is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the *member's* claim for benefits
- If applicable, a statement describing any voluntary appeals procedures and the *member's* right to receive information about the procedures as well as the *member's* right to bring a civil action under Section 502(a) of *ERISA* following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request
- If the decision is based on *medical necessity* or *experimental* treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *member's* medical circumstances, or a statement that such explanation will be provided without charge upon request; and
- The following statement: "You 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."

Expedited Review

You have the right to a more rapid or expedited review of a denial of coverage if a delay: (i) would reasonably appear to seriously jeopardize your or your dependent's life, health or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling BCBSNC Customer Service at the number given in "Whom Do I Call?" An expedited review will take place in consultation with a medical *doctor*. All of the same conditions for a first level or second level *grievance* review apply to an expedited review, except that the review meeting will take place through a conference call or through written communication. BCBSNC will communicate the decision by phone to you and your *provider* as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

After requesting an expedited review, the *Plan* will remain responsible for covered health care services you are receiving until you have been notified of the review decision.

Correspondence related to a request for a review through the *Plan's grievance* process should be sent to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

Delegated Appeals

Magellan Behavioral Health is responsible for the first level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services. Please forward written *grievances* to:

Magellan Behavioral Health
Appeals Department
PO Box 1619

WHAT IF YOU DISAGREE WITH A DECISION? *(cont.)*

Alpharetta, GA 30009
Second level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services is provided by BCBSNC.

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits To Which *Members* Are Entitled

The benefits described in this benefit booklet are provided only for *members*. These benefits and the right to receive payment cannot be transferred to another person. At the option of the *Plan*, payment for services will be made to the *provider* of the services, or the *Plan* may choose to pay the *participant*.

If a *member* resides with a custodial parent or legal guardian who is not the *participant*, the *Plan* will, at its option, make payment to either the *provider* of the services or to the custodial parent or legal guardian for services provided to the *member*. If the *participant* or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the *provider*.

Benefits for *covered services* specified in the *Plan* will be provided only for services and supplies that are performed by a *provider* as specified in the *Plan* and regularly included in the *allowed amount*. BCBSNC establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under the *Plan*.

Any amounts paid by the *Plan* for noncovered services or that are in excess of the benefit provided under your Blue Options coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a *member's* future claim payment. This can result in a reduction or elimination of future claims payments. Amounts paid by the *Plan* for work-related accidents, injuries, or illnesses covered under state workers' compensation laws will be recovered upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the *member*, the employer or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

Providers are independent contractors, and they are solely responsible for injuries and damages to *members* resulting from misconduct or negligence.

BCBSNC's Disclosure Of Protected Health Information (PHI)

BCBSNC takes your privacy seriously and handles all PHI as required by state and federal laws and regulations and accreditation standards. BCBSNC has developed a privacy notice that explains the procedures. To obtain a copy of the privacy notice, visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Administrative Discretion

BCBSNC has the authority to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning coverage of services, care, treatment or supplies, and reasonableness of charges. BCBSNC medical policies are guides considered when making coverage determinations.

Provider Reimbursement

BCBSNC has contracts with certain *providers* of health care services for the provision of, and payment for, health care services provided to all *members* entitled to health care benefits. BCBSNC's payment to *providers* may be based on an amount other than the actual charges, including without limitation, an amount per confinement or episode of care, agreed upon schedule of fees, or other methodology as agreed upon by BCBSNC and the *provider*. Under certain circumstances, a contracting *provider* may receive payments from BCBSNC greater than the charges for services provided to an eligible *member*, or BCBSNC may pay less than charges for services, due to negotiated contracts. The *member* is not entitled to receive any portion of the payments made under the terms of contracts with *providers*. The *member's* liability when defined as a percent of charge shall be calculated based on the lesser of the *allowed amount* or the *provider's* actual charge for *covered services* provided to a *member*.

Services Received Outside Of North Carolina

Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the BlueCard program. Your *ID card* tells participating *providers* that you are a *member* of BCBSNC. By taking part in this program, you may receive discounts from out-of-state *providers* who participate in the BlueCard program.

When you obtain health care services through the BlueCard program outside the area in which the BCBSNC network operates, the amount you pay toward such *covered services*, such as *deductibles*, *copayments* or *coinsurance*, is usually based on the **lesser** of:

- The billed charges for your *covered services*, or
- The negotiated price that the out-of-state Blue Cross and/or Blue Shield licensee ("Host Blue") passes on to BCBSNC.

This "negotiated price" can be:

- A simple discount which reflects the actual price paid by the Host Blue
- An estimated price that factors in expected settlements, withholds, contingent payment arrangements, or other nonclaims transactions, with your health care *provider* or with a group of *providers*
- A discount from billed charges that reflects the **average** expected savings with your health care *provider* or with a group of *providers*. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

The estimated or average price may be adjusted in the future to correct for over- or under-estimation of past prices. However, the amount you pay is considered a final price.

Should any state enact a law that mandates liability calculation methods that differ from the usual BlueCard program method or requires a surcharge, your required payment for services in that state will be based upon the method required by that state's law.

Right Of Recovery Provision

Immediately upon paying or providing any benefit under the *Plan*, the *Plan* shall be subrogated to all rights of recovery a *member* has against any party potentially responsible for making any payment to a *member* due to a *member's* injuries, illness or condition, to the full extent of benefits provided or to be provided by the *Plan*.

In addition, if a *member* receives any payment from any potentially responsible party as a result of an injury, illness or condition, the *Plan* has the right to recover from, and be reimbursed by, the *member* for all amounts the *Plan* has paid and will pay as a result of that injury or illness, up to and including the full amount the *member* receives from all potentially responsible parties. The *member* agrees that if the *member* receives any payment from any potentially responsible party as a result of an injury or illness, the *member* will serve as a constructive trustee over the funds for the benefit of the *Plan*. Failure to hold such funds in trust will be deemed a breach of the *member's* fiduciary duty to the *Plan*.

Further, the *Plan* will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a *member* receives from any third party, any third party's insurer or any other source as a result of the *member's* injuries. The lien is in the amount of benefits paid by the *Plan* for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a *member* due to a *member's* injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The lien can be filed with or enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the *Plan* including, but not limited to, the *member*; the *member's* representative or agent; responsible party; responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the *Plan*.

The *member* acknowledges that the *Plan's* recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the *Plan* before any other claim for the *member's* damages. The *Plan* shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the *Plan* will result in a recovery to the *member* which is insufficient to make the *member* whole or to compensate the *member* in part or in whole for the damages sustained. It is further understood that the *Plan* will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the *Plan* is not required to participate in or pay court costs or attorney fees to any attorney hired by the *member*.

The terms of this entire right of recovery provision shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the *member* identifies the medical benefits the *Plan* provided. The *Plan* is entitled to recover from **any and all** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The *member* acknowledges that BCBSNC has been delegated authority by the *Plan Administrator* to assert and pursue the right of subrogation and/or reimbursement on behalf of the *Plan*. The *member* shall fully cooperate with BCBSNC's efforts to recover benefits paid by the *Plan*. It is the duty of the *member* to notify BCBSNC in writing of the *member's* intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the *member*. The *member* shall provide all information requested by BCBSNC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as BCBSNC may reasonably request.

The *member* shall do nothing to prejudice the *Plan's* recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by the *Plan*.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the *member* and the *Plan* agree that the *Plan Administrator* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The *member* agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as BCBSNC may elect. Upon receiving benefits under the *Plan*, the *member* hereby submits to each such jurisdiction, waiving whatever rights may correspond to the *member* by reason of the *member's* present or future domicile.

Notice Of Claim

The *Plan* will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that *covered services* have been provided to a *member*. If the *member* files the claim, written notice must be given to BCBSNC within 18 months after the *member incurs* the *covered service*, except in the absence of legal capacity of the *member*. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

Notice Of Benefit Determination

BCBSNC will provide an explanation of benefits determination to the *member* or the *member's* authorized representative within 30 days of receipt of a notice of claim if the *member* has financial liability on the claim other than a *copayment* (unless your *Plan* has chosen to provide an explanation of benefits for additional claims where the *member* does not have a financial liability other than a *copayment*). BCBSNC may take an extension of up to 15 additional days to complete the benefits determination if additional information is needed. If BCBSNC takes an extension, BCBSNC will notify the *member* or the *member's* authorized representative of the extension and of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days.

Such notice will be worded in an understandable manner and will include:

- The specific reason(s) for the denial of benefits
- Reference to the benefit booklet section on which the denial of benefits is based
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed
- A description of the review procedures and the time limits applicable to such procedures, including the *member's* right to bring a civil action under Section 502(a) of *ERISA* following a denial of benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request
- If the denial of benefits is based on *medical necessity* or *experimental* treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the health benefit plan to the *member's* medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of a denial of benefits involving *urgent care*, a description of the expedited review process available to such claims.

Upon receipt of a denial of benefits, you have the right to file a *grievance* with BCBSNC. See "What If You Disagree With A Decision?" for more information.

Limitation Of Actions

Since the *Plan* is subject to *ERISA*, you must only exhaust the first level *grievance* review process following the Notice of Claim requirement. Please see "What If You Disagree With A Decision?" for details regarding the *grievance* review process. No legal action may be taken later than three years from the date *covered services* are *incurred*. However, if you are authorized to pursue an action in federal court under *ERISA*, and you choose to pursue a second level *grievance* review, the three-year limitation is temporarily suspended until that review has been resolved.

Coordination Of Benefits (Overlapping Coverage)

If a *member* is also enrolled in another group health plan, the *Plan* may coordinate benefits with the other plan. Coordination of benefits (COB) means that if a *member* is covered by more than one insurance plan, benefits under one plan are determined before the benefits are determined under the second plan. The plan that determines benefits first is called the primary plan. The other plan is called the secondary plan. Benefits paid by the secondary plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service.

Most group health insurance plans include a COB provision. The rules used to determine which plan is primary and secondary are listed in the following chart. The "participant" is the person who is signing up for health insurance coverage.

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	Yes	
	The plan with COB is		Yes
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	Yes	
	The plan covering the person as a dependent is		Yes
The person is covered as a dependent child under both plans, including when parents are divorced or separated and share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	Yes	
	The plan of the parent whose birthday is later in the calendar year is		Yes
	Note: When the parents have the same birthday, the plan that covered the parent longer is	Yes	
The person is covered as a dependent child and parents are divorced or separated with no court decree for coverage	The custodial parent's plan is	Yes	
	The plan of the spouse of the custodial parent is		Yes
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	Yes	
	The non-custodial parent's plan is		Yes
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	Yes	
	The plan of the other parent is		Yes
	Note: If there is a court decree that requires a parent to assume financial responsibility for the child's health care coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent's health benefit plan are	Yes	
The person is covered as a laid-off or retired employee or that employee's dependent, on one of the plans	The plan that covers a person other than as a laid-off or retired employee or as that employee's dependent	Yes	
	The plan that covers a person as a laid-off or retired employee or the dependent of a laid-off or retired employee		Yes
	Note: This rule does not apply if it results in a conflict in determining order of benefits		
The person is the participant in two active group health plans and none of the rules above apply	The plan that has been in effect longer is	Yes	
	The plan that has been in effect the shorter amount of time is		Yes

NOTE: Payment by BCBSNC under the *Plan* takes into account whether or not the *provider* is a participating *provider*. If the *Plan* is the secondary plan, and the *member* uses a participating *provider*, the *Plan* will coordinate up to the *allowed amount*. The participating *provider* has agreed to accept the *allowed amount* as payment in full.

BCBSNC may request information about the other plan from the *member*. A prompt reply will help BCBSNC process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits are coordinated with other group health plans, benefits for *covered services* are still subject to program requirements, such as *prior review* and *certification* procedures.

DEFINITIONS

ALLOWED AMOUNT — the charge that BCBSNC determines is reasonable for *covered services* provided to a *member*. This may be established in accordance with an agreement between the *provider* and BCBSNC. In the case of *providers* that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the *provider's* actual charge or a reasonable charge established by BCBSNC using a methodology that is applied to comparable *providers* for similar services under a similar plan. BCBSNC's methodology is based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the *provider* may be combined into one procedure for reimbursement purposes.

AMBULANCE — transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured, includes ground and aircraft.

AMBULATORY SURGICAL CENTER — a *nonhospital facility* with an organized staff of *doctors*, which is licensed or certified in the state where located, and which:

a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an *outpatient* basis
b) Provides nursing services and treatment by or under the supervision of *doctors* whenever the patient is in the facility
c) Does not provide *inpatient* accommodations
d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a *doctor* or *other provider*.

BENEFIT PERIOD — the period of time, as stated in the "Summary Of Benefits," during which charges for *covered services* provided to a *member* must be *incurred* in order to be eligible for payment by the *Plan*. A charge shall be considered *incurred* on the date the service or supply was provided to a *member*.

BENEFIT PERIOD MAXIMUM — the maximum amount of charges for *covered services* in a *benefit period* that will be reimbursed on behalf of a *member* while covered under the *Plan*.

CERTIFICATION — the determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy BCBSNC's requirements for *medically necessary* services and supplies, appropriateness, health care setting, level of care and effectiveness.

COINSURANCE — the sharing of charges by the *Plan* and the *member* for *covered services* received by a *member*, usually stated as a percentage of the *allowed amount*.

COMPLICATIONS OF PREGNANCY — medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated prior to the full term of the pregnancy (except as otherwise stated below), including, but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. *Emergency* cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as a complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy.

CONGENITAL — existing at, and usually before, birth referring to conditions that are apparent at birth regardless of their causation.

COPAYMENT — the fixed-dollar amount that is due and payable by the *member* at the time a *covered service* is provided.

COSMETIC — to improve appearance. This does not include restoration of physiological function resulting from accidental injury, trauma or previous treatment that would be considered a *covered service*. This also does not include reconstructive *surgery* to correct *congenital* or developmental anomalies that have resulted in functional impairment.

COVERED SERVICE(S) — a service, drug, supply or equipment specified in this benefit booklet for which *members* are entitled to benefits in accordance with the terms and conditions of the *Plan*.

CREDITABLE COVERAGE — accepted health insurance coverage carried prior to BCBSNC coverage can be group health insurance, self-funded plans, individual health insurance, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as creditable coverage under state or federal law. Creditable coverage does not include coverage consisting solely of excepted benefits.

CUSTODIAL CARE — care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*. While some skilled services may be provided, the patient does not require continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by BCBSNC without regard to the place of service or the *provider* prescribing or providing the services.

DEDUCTIBLE — the specified dollar amount for certain *covered services* that the *member* must incur before benefits are payable for the remaining *covered services*. The deductible does not include *copayments, coinsurance*, charges in excess of the *allowed amount*, amounts exceeding any maximum and expenses for noncovered services.

DEFINITIONS *(cont.)*

DENTAL SERVICE(S) — dental care or treatment provided by a *dentist* or *other professional provider* in the *dentist's* office to a covered *member* while the policy is in effect, provided such care or treatment is recognized by BCBSNC as a generally accepted form of care or treatment according to prevailing standards of dental practice.

DENTIST — a dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide *dental services,* perform dental *surgery* or administer anesthetics for dental *surgery.* All services performed must be within the scope of license or certification to be eligible for reimbursement.

DEVELOPMENTAL DYSFUNCTION — difficulty in acquiring the activities of daily living including, but not limited to, walking, talking, feeding or dressing oneself or learning in school. Developmental therapies are those to facilitate or promote the development of skills, which the *member* has not yet attained. Examples include, but are not limited to: speech therapy to teach a *member* to talk, follow directions or learn in school; physical therapy to treat a *member* with low muscle tone or to teach a *member* to roll over, sit, walk or use other large muscle skills; occupational therapy to teach a *member* the activities of daily living, to use small muscle skills or balance or to assist with behavior or achievement in the learning setting.

DOCTOR — includes the following: a doctor of medicine, a doctor of osteopathy, licensed to practice medicine or *surgery* by the Board of Medical Examiners in the state of practice, a doctor of dentistry, a doctor of podiatry, a doctor of chiropractic, a doctor of optometry, or a doctor of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner or scope of practice. All services performed must be within the scope of license or certification to be eligible for reimbursement.

DURABLE MEDICAL EQUIPMENT — items designated by BCBSNC which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home.

EFFECTIVE DATE — the date on which coverage for a *member* begins, according to "When Coverage Begins And Ends."

EMERGENCY(IES) — the sudden or unexpected onset of a condition of such severity 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 an individual or with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock, and other severe, acute conditions are examples of emergencies.

EMERGENCY SERVICES — health care items and services furnished or required to screen for or treat an *emergency* medical condition until the condition is *stabilized,* including pre-hospital care and ancillary services routinely available in the emergency department.

EMPLOYER — Duke Energy Corporation or an affiliated company that is participating in the *Plan.*

ERISA — the Employee Retirement Income Security Act of 1974.

EXPERIMENTAL — see *Investigational.*

FACILITY SERVICES — *covered services* provided and billed by a *hospital* or *nonhospital facility.* All services performed must be within the scope of license or certification to be eligible for reimbursement.

GRIEVANCE — grievances include dissatisfaction with a claims denial or any decisions (including an appeal of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services.

HOLISTIC MEDICINE — unproven preventive or treatment modalities, generally described as alternative, integrative or complementary medicine, whether performed by a physician or any *other provider.*

HOMEBOUND — a *member* who cannot leave their home or temporary residence due to a medical condition which requires both the assistance of another person and the aid of supportive devices or the use of special transportation. A *member* is not considered homebound solely because the assistance of another person is required to leave the home.

HOME HEALTH AGENCY — a *nonhospital facility* which is primarily engaged in providing home health care services medical or therapeutic in nature, and which:

a) Provides skilled nursing and other services on a visiting basis in the *member's* home,
b) Is responsible for supervising the delivery of such services under a plan prescribed by a *doctor,*
c) Is accredited and licensed or certified in the state where located,
d) Is certified for participation in the Medicare program, and
e) Is acceptable to BCBSNC.

HOSPICE — a *nonhospital facility* that provides medically related services to persons who are terminally ill, and which:

a) Is accredited, licensed or certified in the state where located,
b) Is certified for participation in the Medicare program, and
c) Is acceptable to BCBSNC.

HOSPITAL — an accredited institution for the treatment of the sick that is licensed as a hospital by the appropriate state agency in the state where located. All services performed must be within the scope of license or certification to be eligible for reimbursement.

IDENTIFICATION CARD (ID card) — the card issued to *members* upon enrollment which provides *employer/member* identification numbers, names of the *members,* applicable *copayments* and/or *coinsurance,* and key phone numbers and addresses.

DEFINITIONS *(cont.)*

INCURRED — the date on which a *member* receives the service, drug, equipment or supply for which a charge is made.
INFERTILITY — the inability of a heterosexual couple to conceive a child after 12 months of unprotected male/female intercourse.
IN-NETWORK — designated as participating in the Blue Options network. BCBSNC's payment for in-network *covered services* is described in this benefit booklet as in-network benefits or in-network benefit levels.
IN-NETWORK PROVIDER — a *hospital*, *doctor*, other medical practitioner or *provider* of *medical services* and supplies that has been designated as a Blue Options *provider* by BCBSNC or a *provider* participating in the BlueCard program.
INPATIENT — pertaining to services received when a *member* is admitted to a *hospital* or *nonhospital facility* as a registered bed patient for whom a room and board charge is made.
INVESTIGATIONAL (EXPERIMENTAL) — the use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, drug, or device that BCBSNC does not recognize as standard *medical care* of the condition, disease, illness, or injury being treated. The following criteria are the basis for BCBSNC's determination that a service or supply is investigational:

a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply
c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
d) The service or supply under consideration is not as beneficial as any established alternatives
e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

If a service or supply meets one or more of the criteria, it is deemed investigational except for clinical trials as described under the *Plan*. Determinations are made solely by BCBSNC after independent review of scientific data. Opinions of experts in a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered by BCBSNC but are not determinative or conclusive.
LICENSED PRACTICAL NURSE (LPN) — a nurse who has graduated from a formal practical nursing education program and is licensed by the appropriate state authority.
LIFETIME MAXIMUM — the maximum amount of *covered services* that will be reimbursed on behalf of a *member* while covered under the *Plan*.
MAINTENANCE THERAPY — services that preserve your present level of function or condition and prevent regression of that function or condition. Maintenance begins when the goals of the treatment plan have been achieved and/or when no further progress is apparent or expected to occur.
MEDICAL CARE/SERVICES — professional services provided by a *doctor* or *other provider* for the treatment of an illness or injury.
MEDICAL SUPPLIES — health care materials that include ostomy supplies, catheters, oxygen and diabetic supplies.
MEDICALLY NECESSARY (or MEDICAL NECESSITY) — those *covered services* or supplies that are:

a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under the *Plan*, not for *experimental*, *investigational*, or *cosmetic* purposes,
b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms,
c) Within generally accepted standards of *medical care* in the community, and
d) Not solely for the convenience of the insured, the insured's family, or the *provider*.

For medically necessary services, BCBSNC may compare the cost-effectiveness of alternative services, settings or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.
MEMBER — an *participant* or dependent, who is currently enrolled in the *Plan* and for whom premium is paid.
MENTAL ILLNESS — mental disorders, psychiatric illnesses, mental conditions and psychiatric conditions (whether organic or non-organic, whether of biological, nonbiological, chemical or nonchemical origin and irrespective of cause, basis or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC.)
NONCERTIFICATION — a determination by BCBSNC that a service covered under the *Plan* has been reviewed and does not meet BCBSNC's requirements for *medical necessity*, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of *emergency services* and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is *experimental*, *investigational* or *cosmetic* is considered a noncertification. A noncertification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

NONHOSPITAL FACILITY — an institution or entity other than a *hospital* that is accredited and licensed or certified in the state where located to provide *covered services* and is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.
OFFICE VISIT — *medical care, surgery,* diagnostic services, *short-term rehabilitative therapy* services and *medical supplies* provided in a *provider's* office.
OTHER PROFESSIONAL PROVIDER — a person or entity other than a *doctor* who is accredited and licensed or certified in the state where located to provide *covered services* and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.
OTHER PROVIDER — an institution or entity other than a *doctor* or *hospital,* which is accredited and licensed or certified in the state where located to provide *covered services* and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.
OTHER THERAPY(IES) — the following services and supplies, both *inpatient* and *outpatient,* ordered by a *doctor* or *other provider* to promote recovery from an illness, disease or injury when provided by a *doctor, other provider* or professional employed by a *provider* licensed in the state of practice.

a) Cardiac rehabilitative therapy — reconditioning the cardiovascular system through exercise, education, counseling and behavioral change
b) Chemotherapy (including intravenous chemotherapy) — the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the Food and Drug Administration (FDA)
c) Dialysis treatments — the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis
d) Pulmonary therapy — programs that combine exercise, training, psychological support and education in order to improve the patient's functioning and quality of life
e) Radiation therapy — the treatment of disease by x-ray, radium, or radioactive isotopes
f) Respiratory therapy — introduction of dry or moist gases into the lungs for treatment purposes.

OUT-OF-NETWORK — not designated as participating in the Blue Options network, and not certified in advance by *BCBSNC* to be considered as *in-network*. There is no payment for out-of-network *covered services* except as described in this benefit booklet.
OUT-OF-NETWORK PROVIDER — a *provider* that has not been designated as a Blue Options *provider* by BCBSNC.
OUTPATIENT — pertaining to services received from a *hospital* or *nonhospital facility* by a *member* while not an *inpatient.*
OUTPATIENT CLINIC(S) — an accredited institution/facility associated with or owned by a *hospital.* An outpatient clinic may bill for *outpatient* visits, including professional services and ancillary services, such as diagnostic tests. These services may be subject to the *Outpatient* Services benefit. All services performed must be within the scope of the professional or facility license or certification to be eligible for reimbursement.
PARTICIPANT — a person who is eligible for coverage under the *Plan* and properly enrolled.
PLAN — Duke Energy Medical Plan's Exclusive Provider Organization (EPO) option.
PLAN ADMINISTRATOR — Duke Energy Benefits Committee.
PLAN SPONSOR — Duke Energy Corporation.
POSITIONAL PLAGIOCEPHALY — the asymmetrical shape of an infant's head due to uneven external pressures on the skull in either the prenatal or postnatal environment. This does not include asymmetry of an infant's head due to premature closure of the sutures of the skull.
PREVENTIVE CARE — *medical services* provided by or upon the direction of a *doctor* or *other provider* related to the prevention of disease.
PRIMARY CARE PROVIDER (PCP) — an *in-network provider* who has been designated by BCBSNC as a PCP.
PRIOR REVIEW — the consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of *medical necessity* of services and supplies, appropriateness, health care setting, or level of care and effectiveness. Prior review results in *certification* or *noncertification* of benefits.
PROSTHETIC APPLIANCES — fixed or removable artificial limbs or other body parts, which replace absent natural ones following permanent loss of the body part.
PROVIDER — a *hospital, nonhospital facility, doctor,* or *other provider,* accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification. All services performed must be within the scope of license or certification to be eligible for reimbursement.
REGISTERED NURSE (RN) — a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program), and is licensed by the appropriate state authority in the state of practice.
ROUTINE FOOT CARE — hygiene and preventive maintenance such as trimming of corns, calluses or nails that do not usually require the skills of a qualified *provider* of foot care services.
SEXUAL DYSFUNCTION — any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

SHORT-TERM REHABILITATIVE THERAPY — services and supplies both *inpatient* and *outpatient*, ordered by a *doctor* or *other provider* to promote the recovery of the *member* from an illness, disease or injury when provided by a *doctor, other provider* or professional employed by a *provider* licensed by the appropriate state authority in the state of practice and subject to any licensure or regulatory limitation as to location, manner or scope of practice.

a) Occupational therapy — treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role after such ability has been impaired by disease, injury or loss of a body part
b) Physical therapy — treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part
c) Speech therapy — treatment for the restoration of speech impaired by disease, *surgery*, or injury; or certain significant physical *congenital* conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

SKILLED NURSING FACILITY — a *nonhospital facility* licensed under state law that provides skilled nursing, rehabilitative and related care where professional *medical services* are administered by a registered or *licensed practical nurse*. All services performed must be within the scope of license or certification to be eligible for reimbursement.

SPECIALIST — a *doctor* who is recognized by BCBSNC as specializing in an area of medical practice.

STABILIZE — to provide *medical care* that is appropriate to prevent a material deterioration of the *member's* condition, within reasonable medical certainty.

SURGERY — the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures, such as:

a) The correction of fractures and dislocations
b) Usual and related pre-operative and post-operative care
c) Other procedures as reasonable and approved by BCBSNC.

TRANSPLANTS — the surgical transfer of a human organ or tissue taken from the body for grafting into another area of the same body or into another body; the removal and return into the same body or transfer into another body of bone marrow or peripheral blood stem cells. Grafting procedures associated with reconstructive *surgery* are not considered transplants.

URGENT CARE — services provided for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis or treatment, such that in the absence of immediate care the individual could reasonably be expected to suffer chronic illness, prolonged impairment, or require a more hazardous treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

UTILIZATION MANAGEMENT (UM) — a set of formal processes that are used to evaluate the *medical necessity*, quality of care, cost-effectiveness and appropriateness of many health care services, including procedures, treatments, medical devices, *providers* and facilities.

WAITING PERIOD — the amount of time that must pass before a *member* is eligible to be covered for benefits under the terms of the *Plan*.

BlueCross BlueShield of North Carolina

MEMBER'S AUTHORIZATION REQUEST FORM
COMMERCIAL OPERATIONS / IDC

You may give Blue Cross and Blue Shield of North Carolina (BCBSNC) written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that BCBSNC communicates with members or subscribers. *For example, we will send explanation of benefits (EOB) statements to the subscriber.***

MEMBER WHOSE INFORMATION WILL BE DISCLOSED:

MEMBER'S FIRST NAME | M.I. | MEMBER'S LAST NAME

MONTH DAY YEAR — MEMBER'S DATE OF BIRTH | PREFIX | 9 DIGIT IDENTIFIER — SUBSCRIBER ID NUMBER *(FROM YOUR ID CARD)* | SUFFIX

At my request, I authorize BCBSNC to disclose Protected Health Information to *(enter name of person/entity who will receive member's PHI)*:

FIRST NAME | M.I. | LAST NAME

RELATIONSHIP TO MEMBER:

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: **(i)** your subscriber ID number, **(ii)** your date of birth, and **(iii)** subscriber address.

I authorize BCBSNC to disclose the following PHI to the person/entity listed above. CHECK ONLY BOXES THAT APPLY:

☐ ALL Information Requested ☐ Enrollment Information ☐ Benefit Information ☐ Premium Payment Information ☐ Explanation of Benefits (EOB) Information

☐ All Claims Information ☐ All Services from a Specific Health Care Provider(s) *(List Provider's Name)*: _____

☐ Other *(Please List Specific PHI and/or Date Ranges)*: _____

If you want to authorize someone to have access to your mental health or substance abuse PHI, please call the mental health/substance abuse company's telephone number on the back of your membership card to request a separate authorization form from them.

NOTE: BCBSNC will consider the effective date of this authorization to be the date BCBSNC enters this authorization into its Commercial Operations business system, typically five (5) days following receipt.

If you would like this authorization to become effective on a date after BCBSNC enters the authorization into its system, please insert the date here: → MONTH DAY YEAR

I would like this authorization to expire on *(enter date)*: MONTH DAY YEAR **OR** ☐ **When my policy expires.**

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)

I understand that I may revoke this authorization at any time by giving BCBSNC written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will not affect any action BCBSNC took in reliance on this authorization before BCBSNC received my written notice of revocation.

I also understand that BCBSNC will not condition the provision of health plan benefits on this authorization.

I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act ("HIPAA") or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature: _____ **Today's Date:** MONTH DAY YEAR

If signed by an individual other than the member: _____
PRINT YOUR FULL NAME

Describe your authority to act for the member *(e.g., power of attorney, court order, parent of minor child, etc.)*:

_____

NOTE: Please attach the legal document naming you as the personal representative if you have not previously submitted it to us.

RETURN THIS AUTHORIZATION TO: Commercial Operations / IDC
Blue Cross and Blue Shield of North Carolina
P.O. Box 2291 • Durham, NC 27702-2291

U2516, 1/04

SUMMARY OF BENEFITS

This section provides a summary of your Blue Options benefits. A more complete description of your benefits is found in "*Covered Services.*" General exclusions may also apply — please see "What Is Not Covered?" As you review the "Summary Of Benefits" chart, keep in mind:

- To receive benefits, you must receive care from a Blue Options *in-network provider.* **However, in an *emergency*, or when *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, you may also receive *in-network* benefits for care from an *out-of-network provider.* Please see "*Out-Of-Network* Benefits" and "*Emergency* Services" for additional information. Access to care standards are available on the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or by calling BCBSNC Customer Service at the number listed on your *ID card* or in "Whom Do I Call?"**
- *Copayment* amounts are fixed dollar amounts the *member* must pay for some *covered services*
- Multiple *office visits* or emergency room visits on the same day may result in multiple *copayments*
- *Coinsurance* percentages shown in this section are the portion of the *allowed amount* that the *Plan* covers
- *Coinsurance* amounts are based on the *allowed amount.*

Please note: The list of *in-network providers* may change from time to time, so please verify that the *provider* is still in the Blue Options network before receiving care. Find a *provider* on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed on your *ID Card* or in "Whom Do I Call?"

Benefit period January 1 through December 31

Benefit payments are based on where services are received and how services are billed.

In-network

Physician Office Services

See *Outpatient* Services for *outpatient clinic* or *hospital*-based services. *Office visits* for the evaluation and treatment of obesity are limited to a maximum of four visits per *benefit period.*

Office Services	
Primary Care Provider	$30 *copayment*
Specialist	$30 *copayment*
Includes office *surgery*, x-rays and lab tests.	
CT Scans, MRIs, MRAs and PET Scans	$30 *copayment*
Preventive Care	
Primary Care Provider	$30 *copayment*
Specialist	$30 *copayment*
Includes routine physical exams, well baby, well-child care, immunizations, gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests (PSAs).	
Short-term Rehabilitative Therapies	$30 *copayment*
Chiropractic Services	$30 *copayment*
Benefit period maximums apply to home, office and *outpatient* settings. 80 visits per *benefit period* for speech therapy, physical/occupational therapy, and chiropractic services combined.	

SUMMARY OF BENEFITS *(cont.)*

	In-network
Physician Office Services (cont'd)	
Other Therapies	100%
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See *Outpatient* Services for *other therapies* provided in an *outpatient* setting.	
***Infertility* and *Sexual Dysfunction* Services**	
Primary Care Provider	$30 *copayment*
Specialist	$30 *copayment*
Routine Eye Exam	$30 *copayment*
***Urgent Care* Centers and Emergency Room**	
***Urgent Care* Centers**	$40 *copayment*
Emergency Room Visit	$75 *copayment*
If admitted to the *hospital* from the emergency room, *inpatient hospital* benefits apply to all *covered services* provided. If held for observation, *outpatient* benefits apply to all *covered services* provided. If you are sent to the emergency room from an *urgent care* center, you may be responsible for both the emergency room *copayment* and the *urgent care copayment*.	
Ambulatory Surgical Center	$50 *copayment*
***Outpatient* Services**	
Physician Services	100%
***Hospital* and *Hospital*-based Services**	100%
***Outpatient Clinic* Services**	100%
Outpatient Diagnostic Services:	
Outpatient lab tests and mammography when performed alone	100%
Outpatient lab tests and mammography when performed with another service	100%
Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	100%
CT scans, MRIs, MRAs and PET scans	$50 *copayment*
Therapy Services	100%
Includes *short-term rehabilitative therapies* and *other therapies* including dialysis; see "Physician Office Services" for visit maximums.	
***Inpatient Hospital* Services**	
Physician Services	100%
***Hospital* and *Hospital*-based Services**	$125 per admission *copayment*, then 100%
Includes maternity delivery, prenatal and post-delivery care. If you are in a *hospital* as an *inpatient* at the time you begin a new *benefit period*, you may have to meet a new *deductible* for *covered services* from *doctors* or *other professional providers*.	
Skilled Nursing Facility	100%
Maximum of 60 days per *benefit period*.	

In-network

Other Services — 100%

Includes *ambulance, durable medical equipment, hospice* services, *medical supplies,* orthotic devices, private duty nursing, *prosthetic appliances,* and *home health care.* Orthotic devices for correction of *positional plagiocephaly* are limited to a *lifetime maximum* of $600.

Lifetime Maximum and *Coinsurance Maximum*

The following maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.

Lifetime Maximum — Unlimited

Unlimited for all services, except orthotic devices for *positional plagiocephaly* and substance abuse.

Coinsurance Maximum

Individual, per *benefit period*	$1,000
Family, per *benefit period*	$2,000

Charges for the following do not apply to the *benefit period coinsurance maximum:*

- mental health and substance abuse services.

Penalty For Failure To Obtain *Certification*

Certain services require *prior review* and *certification* by BCBSNC in order to receive benefits. You are responsible for requesting or ensuring that your *provider* requests *prior review* by BCBSNC. **Failure to request *prior review* and receive *certification* may result in allowed charges being reduced by 50% or full denial of benefits. See "Prospective Review/*Prior Review*" in "*Utilization Management.*"**

Prior review and *certification* by Magellan Behavioral Health are required for *inpatient* and *outpatient* mental health and substance abuse services, except for *emergencies.* Please see the number in "Whom Do I Call?"

	In-network
Mental Health And Substance Abuse Services	
Prior review and *certification* by Magellan Behavioral Health are required for *inpatient* and *outpatient* services. Please see the number in "Whom Do I Call?"	
Mental Health Office Services Limited to a maximum of 30 *office visits* per *benefit period.*	$30 *copayment*
Mental Health *Inpatient/Outpatient* Services Limited to maximum of 30 days per *benefit period.*	100%
Substance Abuse Office Services	$30 *copayment*
Substance Abuse *Inpatient/Outpatient* Services	100%
Substance Abuse *Benefit Period Maximum*	None
Substance Abuse *Lifetime Maximum*	$16,000

Prescription Drug Program Guide for Duke Energy Medical Plan

medco® manages your prescription drug benefit for Duke Energy.

Prescription Drug Program

The Duke Energy Medical Plan options include outpatient prescription drug coverage currently administered by Medco Health Solutions, Inc. ("Medco"). Medco is a national pharmacy benefit manager with participating retail pharmacies that include Wal-Mart, Rite Aid, Walgreens, CVS, and others. The prescription drug program can help you save on medically necessary prescribed medications at retail pharmacies and through **Medco By Mail**, a home delivery pharmacy service.

Through the prescription drug coverage, you can:

- Purchase up to a 30-day supply of prescription medications at a participating retail pharmacy.
- Use **Medco By Mail** for up to a 90-day supply of prescription medications.
- Use online resources at www.medco.com to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- Reach Medco Member Services representatives, 24 hours a day, 7 days a week (except Thanksgiving and Christmas when holiday schedules apply) at 1-800-987-8361. Pharmacists are also available around the clock for medication consultations.

Medical Plan and Health Care Spending Account

(Applicable only to active employees)

The prescription drug program copays do not apply to your Medical Plan deductible or coinsurance maximum, if applicable. 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 amounts and copays with before-tax dollars by filing for reimbursement from your HCSA, using your HCSA debit card, or through the HCSA automatic reimbursement feature.

Retail Prescription Drug Program Deductible for Catastrophic Coverage Option

(Applicable only to certain retirees)

If you are enrolled in the Medical Plan's Catastrophic B coverage option, each covered individual has a $200 annual individual retail prescription drug deductible for prescription purchases made at participating retail pharmacies. The $200 deductible is separate from the Medical Plan's Catastrophic B coverage option deductible. Each covered person must meet the annual deductible before the prescription drug program copays apply to retail prescription drug purchases for that person. When you make retail prescription drug purchases at a participating pharmacy that are applied toward the prescription drug annual deductible, you will pay 100% of Medco's negotiated price for the medication that you are purchasing. When you reach the point where the amount of a prescription drug purchase will allow you to meet your annual deductible, you will pay the remaining amount of the deductible and the applicable copay amount.

For example, if the amount of your prescription purchase is $90 and there is $25 remaining to meet your annual deductible, you will pay $25, which is applied to the deductible, and the applicable copay amount for the purchase of the prescription drug.

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 for each person. You may also call Medco's Member Services to determine the portion of the deductible that has been satisfied to date.

If you are enrolled in any option other than the Medical Plan's Catastrophic B option, you are not required to satisfy an annual deductible before the prescription drug program copays apply to retail prescription drug purchases.

Formulary

Your prescription drug program includes a tiered formulary. A formulary is a list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings for the member and the Medical Plan. Due to the tiered formulary, your copay amount for prescription purchases will vary depending on whether your physician prescribes a generic, preferred brand-name or non-preferred brand-name medication. By asking your physician to prescribe generic or preferred brand-name medications, you can help control rising health care costs.

To find out whether a medication is included in the tiered formulary, visit Medco online at www.Medco.com. If you are a first time visitor to the site, please take a moment to register. Please have your member ID number available. After you log in, click "Learn about formularies" in the "Prescriptions & benefits" section. Search for a specific drug to determine if it is on the formulary. A formulary guide is included in your Medco Welcome Kit and you may also call Medco Member Services and request that a formulary guide be mailed to your home. See the prescription drug program summary of benefits for more information about applicable copays for generic, preferred brand-name and non-preferred brand-name medication.

Filling Your Prescription at a Retail Pharmacy

You can fill a prescription at a retail pharmacy for up to a 30-day supply. You will simply show your Medco ID card (with the Medco group number) at the time of your purchase. After meeting any applicable deductibles, you will pay the applicable prescription drug copay.

- If you don't identify yourself to the pharmacist as a Medco participant, or if you go to a non-participating pharmacy, you will have to pay the full price when you pick up the prescription and then submit a paper claim to Medco for reimbursement. You will be reimbursed based on the Medco negotiated price for the medication, less any required deductible and copay. Retail pharmacies that participate in the Medco retail pharmacy 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 Medco 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 participating retail pharmacy and do not identify yourself as a Medco participant by presenting your Medco 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 Medco ID card and ask the pharmacist to submit the order using the original dispensing date. Please confirm that 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 copay. This process will eliminate your need to submit a paper claim to Medco for reimbursement.

Retail Refill Allowance (Mandatory Mail) After Three Retail Refills

Generally, a 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 the Medical Plan's prescription drug program, you must use **Medco By Mail** to receive prescription coverage benefits for your maintenance medication purchases. Here's how it works:

- Beginning with the 4th retail fill of a covered maintenance medication, you will pay the entire cost of that maintenance medication if you continue to purchase it at a participating retail pharmacy. However, if you use Medco's mail-order service, **Medco By Mail**, you will pay the applicable mail order copay amount for up to a 90-day supply.
- The first three times that you purchase each maintenance medication at a participating retail pharmacy, you will pay your participating retail pharmacy copay (for members enrolled in the Medical Plan's Catastrophic B coverage option, the deductible must be met before the copay will apply). After that, you will pay the entire cost of each maintenance medication unless you choose to order through **Medco By Mail**.
- You should continue to purchase your prescriptions for short-term use, such as antibiotics, at a participating retail pharmacy. You'll pay the applicable participating retail pharmacy copay for up to a 30-day supply.

The list of maintenance medications that are addressed by the Retail Refill Allowance provision is subject to change at any time. Visit **www.medco.com** and click "Price a medication" to find out whether your medication is considered a maintenance medication and whether it is affected by any plan limits, or you may call Medco directly for more information.

Using Medco By Mail

The prescription drug program includes **Medco By Mail**, a home delivery pharmacy service, which offers a greater discount on the cost of maintenance medication and a larger supply (up to a 90-day supply) per prescription. Refer to the Retail Refill Allowance section above for a description of what constitutes a maintenance medication. To use **Medco By Mail**:

1. Ask your physician to prescribe your maintenance medication for up to a 90-day supply, plus refills for up to one year, if appropriate.
2. Mail your prescription, along with an order form and the required copay, to Medco. Order forms are available online on the Duke Energy Portal and at **www.medco.com**, or you may call Medco to request a supply of order forms.
3. Once you have established your prescription through **Medco By Mail**, you can order refills online. You will need to enter your member number (from your Medco ID card), enter the prescription number for the medication you wish to refill and verify your address. A detailed summary of your order, including costs, will be available for viewing online. Similar information will be included with your prescription when it is mailed to you.
4. You may also ask your physician to call **1-888-EASYRX1 (1-888-327-9791)** for instructions on how to fax the prescription. Remember to give your physician your Member ID and Medco group numbers (as shown on your Medco ID card); both numbers will be required for your prescription order.

If your prescription is written for less than a 90-day supply, the prescription will be filled in accordance with the day supply your physician ordered, but you will pay the entire **Medco By Mail** copay. If the medication is a federal legend, maintenance medication, a Medco pharmacist will review the prescription

and notify you if the prescription is less than the maximum days' supply available at mail. The pharmacist will offer to contact your physician on your behalf to obtain a new prescription. Please note there are certain situations that may preclude the pharmacist from contacting you directly, such as if the medication is a controlled substance, a specialty drug, or a compounded prescription.

Your prescription will be delivered to your home within 14 calendar days. With a **Medco By Mail** prescription, you will receive materials explaining the purpose of the drug, correct dosages and other helpful information. **When a prescription is ordered using Medco By Mail, Medco will automatically dispense the generic equivalent if one is available and permissible by law, unless your physician has indicated that substitution is not allowed.**

Send mail order prescriptions to:
Medco Mail Order Pharmacy
PO BOX 650322, Dallas TX 75265

Accredo Health Group – Medco's Specialty Care Pharmacy

Specialty medications are typically injectable medications administered either by you or a healthcare professional, and they often require special handling.

Conditions and therapies for which specialty medications are typically used include:

- Age-related macular degeneration
- Alpha-1 proteinase deficiency
- Anemia
- Anti-infective therapy
- Asthma
- Cancer
- Cystic fibrosis
- Deep vein thrombosis
- Fabry disease
- Gaucher disease
- Growth hormone deficiency
- Hemophilia
- Hepatitis C
- Hereditary tyrosinemia
- HIV
- Hyperparathyroidism
- Immune deficiency
- Infertility
- Insulin-like growth factor therapy
- Iron chelation therapy
- Mucopolysaccharidosis
- Multiple sclerosis
- Neutropenia
- Osteoarthritis
- Osteoporosis
- Parkinson disease
- Pompe disease
- Psoriasis
- Pulmonary hypertension
- Respiratory syncytial virus
- Rheumatoid arthritis

Under your prescription drug program, some specialty medications may *not* be covered at participating retail pharmacies or through **Medco By Mail**, but instead may only be covered when ordered through ***Accredo Health Group***, Medco's specialty care pharmacy. Accredo is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling. Services include:

- Toll-free access to specially trained pharmacists 24 hours a day, 7 days a week
- Personalized counseling from our dedicated team of registered nurses and pharmacists
- Expedited, scheduled delivery of your medications at no extra charge
- Refill reminder calls

- Coordination of home care and other healthcare services
- Free supplies, such as needles and syringes, to administer your medication

To find out whether any of your specialty medications need to be ordered through Accredo, please call Medco Member Services at the toll-free number on your prescription drug ID card.

Medicare Part B Medications

(*Applicable only to Medicare Part B enrollees*)

If you are eligible for Medicare Part B coverage and use a participating Medicare Part B retail pharmacy, you may not have to incur out-of-pocket expenses for your Medicare Part B-eligible medications and supplies*. Medicare Part B-eligible prescriptions may be filled through the **Medco By Mail** mail-order pharmacy or at a participating Medicare Part B retail pharmacy. In either case, the pharmacy will verify coverage and file your prescription claims with Medicare, and bill you if any balance is due. For more information about Medicare Part B coverage, call Medco Member Services toll-free at 1-800-987-8361, or visit **www.Medco.com.**

**Medicare Part B coverage will begin only after you have paid your Medicare deductible.*

Some of the medications and supplies typically covered by Medicare Part B include:

- Diabetic supplies (test strips, meters)
- Medications to aid tissue acceptance from Medicare-covered organ transplants
- Certain oral medications used to treat cancer
- Certain medications used in situations where the kidneys have completely failed

If you have Medicare Part B coverage, you will be able to fill prescriptions like these in one of two ways:

- **Medicare Part B Mail-Order Pharmacy**—When using mail order for your medication or supply needs, you will initially send your prescription to **Medco By Mail**. Then, depending on the type of medication or supply requested, **Medco By Mail** will transfer your prescription information to one of two Medicare Part B participating mail-order pharmacies—**Liberty Medical** or **Accredo Health Group**, Medco's specialty care pharmacy. Both Liberty and Accredo have extensive experience with Medicare Part B and will support the dispensing and billing of your prescriptions. They will verify coverage, file your prescription claim with Medicare, and bill you for any balance due. Depending on the covered medications or supplies that you need, Liberty or Accredo will mail your Medicare Part B medications and supplies directly to you and provide instructions for obtaining refills.
- **Medicare Part B Retail Pharmacy**—When using a participating 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 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 Coordination of Benefits processing is available and coordinated by the Part B providers. The provider will submit claims on behalf of the member to Medicare for processing as primary. Once payment is received from Medicare, the Part B provider will submit a secondary claim to Medco and the claim will process under the secondary benefit, if that is offered (for example, Medicare would pay 80% of the claim as primary, and the client would pay 20% of the claim as secondary).

A word about prescriptions covered by Medicare Part B
For more details about which medications or supplies are Medicare Part B–eligible and to learn more about your Medicare coverage:

- Visit the Medicare website at **www.medicare.gov**.
- Call Medicare Customer Service at **1 800 MEDICARE** (1 800 633-4227).

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 **Medco By Mail** or at a participating retail pharmacy (using your Medco 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.

Generic Drugs

For prescription medications, the brand-name is the product name under which a drug is advertised and sold. Generic equivalent medications contain the same active ingredients and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name counterparts. Generally, generic drugs cost less than a brand-name drug. Whenever appropriate, you should ask your physician to prescribe generic drugs. Sometimes your physician may prescribe a medication as "dispense as written" when a preferred brand-name or generic equivalent drug is available. As part of your prescription drug program, the pharmacist may discuss with your physician whether an equivalent generic or preferred brand-name drug might be appropriate for you. The final decision on your medication always rests with you and your physician, even if that decision results in a higher cost to you for your prescription medication.

Covered Expenses

The following are covered expenses unless listed as an exclusion below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes (covered at a $0 copay)
- Over-the-Counter (OTC) Diabetic Supplies (lancets, insulin syringes and needles are covered at $0 copay)
- Oral, Transdermal, Intravaginal and Injectable Contraceptives
- Drugs to Treat Impotency (all dosage forms except Yohimbine) for males age 18 and over
- Yohimbine (covered without the limits that exist for other impotency products)
- Inhaler Assisting Devices
- Peak flow meters
- Synagis/Respigam
- Hemophilia Factors
- Fertility Agents (100% covered after standard copay, up to $2500 per person per lifetime, then member pays 50% of the cost of the drug)
- Zyban and Chantix (limit of 180 days of therapy per year and 360 days of therapy per lifetime)

- Substance abuse treatments
- Dental Fluoride Products
- Anti obesity Agents (covered **Medco By Mail** only)
- Products packaged as greater than a 30 days supply are covered at mail only

Coverage limits for Certain Medications

Your prescription drug program may have certain coverage limits. For example, some quantities may be limited or some prescriptions require a coverage review. Examples of drugs with limitations or requiring coverage review are Provigil, Human Growth Hormones, Impotency Products, and Proton Pump Inhibitors (Prevacid, Protonix, Aciphex, Zegerid). Refer to www.Medco.com or call member services at 1-800-987-8361 for details.

Dispensing Limits

- The amount of drug which is to be dispensed per prescription or refill (regardless of dosage form) will be in quantities prescribed up to a 30-day supply at a participating retail pharmacy and up to a 90-day supply through **Medco By Mail**
- Thalomid limited to a 28 day supply at both retail and **Medco By Mail**

Excluded Expenses

The following are excluded from coverage 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 under the Medical Plan)
- Glucowatch Products
- Anti-obesity meds at retail
- 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
- Biologicals, Immunization agents or Vaccines
- Blood or blood plasma products
- 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 any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member
- 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

Coordination of Benefits for the Prescription Drug Program

Under the prescription drug program, Medco 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 deductible and coinsurance, you may want to use your Medco ID Card, instead of your spouse/domestic partner's plan, to obtain your prescriptions.

Please Note: Medco does coordinate benefits for Medicare Part B. Please see section titled "Medicare Part B Medications" for more details.

How to File a Prescription Drug Program Claim

When you fill your prescription at a participating retail pharmacy and identify yourself as a Medco 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, if any, and the copay.

If you do not identify yourself to the pharmacist as a Medco participant, or if you do not use a participating pharmacy, you will need to file a claim for reimbursement of your prescription drug expenses through Medco. 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, the cost, the strength, quantity, and days supply of medication, the name of the medication, prescription number and NDC number. When you submit an original receipt, keep a copy for your records. Claim reimbursement is limited to Medco's discounted price less any required deductible and copay. Medco 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 prescription medication on January 15, 2009, from a non-participating pharmacy, you must file your claim by April 15, 2010, to receive reimbursement for your expenses. Duke Energy offers new Medco prescription participants a 45-day grace period for prescription drug claims purchased at full cost in situations where the prescription ID card was not used. The grace period allows members to be reimbursed at 100%, less the applicable deductible and copay, for paper claims submitted within 45 days from a participant's initial eligibility effective date with Medco. For example, a participant who's initial effective date with Medco is January 1, 2009 would have 45 days (until February 14, 2009) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether the pharmacy was a participating or non-participating.

To obtain a claim form, call Medco Member Services at 1-800-987-8361, or go online to **www.medco.com**.

Submit claim forms to:
Medco Health Solutions, Inc.
PO Box 14711
Lexington, KY 40512

Reviews & Appeals

Medco will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Medco's control, it will notify you or your representative within 15 days after receiving the request. The extension notice will include 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 Medco 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 45 days to respond to the request for information.

Notice of Adverse Determination

In the event of an adverse benefit determination, in whole or in part, you (or your authorized representative) 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 plan benefit. An adverse benefit determination notification for any prescription drug plan claim will contain:

- 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 review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; and
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim.

When You Have a Complaint or an Appeal

If your claim is denied, you may request a full review by Medco within 180 days of the date of the adverse benefit determination. Your written letter of appeal should include the following:

- your name and member 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 Medco 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 Medco in reviewing your claim. You may request reasonable access to copies of all documents, records, and other information relevant to your claim. Medco 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. Your appeal should be mailed to:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving TX 75063
1-800-987-8361

Medco will notify you of its decision on your appeal within 15 days of its receipt of your 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:

- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and the claimant's right to bring an action under ERISA section 502(a);
- upon request and free of charge, reasonable access will be provided to copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal.

Second Level Appeal Process

If your claim is denied on appeal, you have a right to bring a second 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. Medco 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.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or Duke Energy 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.

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 Appeals Procedure. You may not initiate a legal action until you have completed the first and second level 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

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 Medco's 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 Medco at the address listed above.
Call Medco Member services for additional information regarding the appeals process.

This is a guide of covered expenses and expenses not covered under the prescription drug program. For more information about applicable deductibles, copays and plan limits, please call Medco Member Services or visit www.Medco.com. For more detailed information on the Medical Plan, refer to the Duke Energy Medical Plan General Information Booklet and BCBSNC Benefits Booklet sections of this Summary Plan Description. The official plan documents govern plan provisions and payment of plan benefits.

medco®

SUMMARY OF PRESCRIPTION DRUG BENEFITS

Annual Deductible (per person*) – *applies to retail pharmacy purchases*	$0	
Prescription Drug Co-pays		
You must show your Medco ID card	**Retail Pharmacy (up to a 30-day supply)**	**Mail Order (up to a 90-day supply)**
Generic	$15	$36
Preferred Brand	$30	$70
Non-Preferred Brand	$55	$90

*There is no annual family prescription drug deductible.

Medical Plan Benefits

Exclusive Provider Organization (EPO) option #2

Duke Energy®

01/2009

Inside you will find:

- SECTION I: Duke Energy Medical Plan—General Information
- SECTION II: BCBSNC Benefit Booklet (includes Summary of Medical Benefits)
- SECTION III: Medco Prescription Drug Guide
- SECTION IV: Summary of Prescription Drug Benefits

The Duke Energy Medical Plan
General Information

IMPORTANT NOTICE

This General Information booklet for The Duke Energy 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 election 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 2009 and replaces all prior descriptions of the Medical Plan. It is intended to provide an easy-to-understand explanation of your benefits.

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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, pharmacy, wellness and disease management benefits.

Based on your location and employee or retiree group, there are various Medical Plan coverage options available, such as exclusive provider organization (EPO), preferred provider organization (PPO) and high-deductible health plan (HDHP) options. If you do not have adequate access to network providers, you may qualify for out-of-area (OOA) options that mirror the PPO options. All of the Medical Plan options are designed to help you pay for health care expenses.

myHR Service Center

If you have any questions about the Medical Plan or the information in this General Information booklet, contact the myHR Service Center at 1-888-465-1300. Representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time. Information is also available through the Your Benefits Resources™ (YBR) Web site 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 (collectively referred to with Duke Energy as the "Company") 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.

International Assignment

When you are assigned by your Company to work outside the U.S. for a period that is initially expected to last at least nine consecutive months, you will cease to be eligible for the Medical Plan options available to employees on U.S. domestic assignment.

Instead, you will be eligible for the Medical Plan's special international assignment coverages. These coverages are described in a special booklet and not in the Medical Plan's General Information booklet or the other Medical Plan booklets.

Eligible Retirees

If your employment terminates on or after January 1, 2009, to be eligible for retiree coverage under the Medical Plan, at termination of employment you must:

- be employed by a Company that offers access to retiree coverage under the Medical Plan; and
- be at least age 50 and credited with at least 5 years of retiree eligibility service.

Contact the myHR Service Center if you want to know if a particular Company offers access to retiree coverage under the Medical Plan.

If your Company employment terminated before January 1, 2009, 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 for your eligible spouse and/or child(ren). If you are a Legacy Duke employee[†] who retires on or after January 1, 2006, you may be eligible to elect coverage for your eligible domestic partner. If you are a Legacy Duke employee who retired before January 1, 2006, or if you are a Legacy Cinergy retiree[‡], you are not eligible to elect coverage for your domestic partner. Please refer to the sections *Enrolling in the Medical Plan – Eligible Retirees* and *Mid-Year Coverage Changes* for additional information.

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)[*]

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."

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, which may include "common law marriage," and the spouse must meet the federal tax requirement of being a person of the opposite sex who is the taxpayer's husband or wife.

[†] When used in this booklet, the term "Legacy Duke" refers to an individual who (1) terminated employment with Duke Energy Corporation, a North Carolina corporation, and its affiliates prior to the merger of Cinergy Corp. and Duke Energy Corporation, a North Carolina corporation, (2) was employed by Duke Energy Corporation, a North Carolina corporation, and its affiliates immediately prior to such merger or (3) except as provided in footnote 2 below, was hired following such merger by a payroll company that was affiliated with (or has been designated as having been affiliated with) Duke Energy Corporation, a North Carolina corporation, immediately prior to such merger.

[‡] When used in this booklet, the term "Legacy Cinergy" refers to an individual who (1) terminated employment with Cinergy Corp. and its affiliates prior to the merger of Cinergy Corp. and Duke Energy Corporation, a North Carolina corporation, (2) was employed by Cinergy Corp. and its affiliates immediately prior to such merger, (3) was hired following such merger by a payroll company that was affiliated with (or has been designated as having been affiliated with) Cinergy Corp. immediately prior to such merger or (4) was hired by Duke Energy Business Services, LLC on or after July 1, 2008 at a work location such that he or she would have been employed by Duke Energy Shared Services, Inc. if he or she was hired to work at such location immediately prior to July 1, 2008 and he or she is so designated as Legacy Cinergy in accordance with rules prescribed by the Plan Administrator.

[§] See *Eligible Retirees* for information regarding eligible retirees' ability to elect coverage for a domestic partner.

[*] A child of divorced parents will generally be recognized by Section 152(e) of the Internal Revenue Code as a dependent of both parents for purposes of coverage under the Medical Plan.

By enrolling a spouse, you represent that the individual meets these requirements. You must immediately drop coverage for a spouse who no longer meets these requirements.

Domestic Partner Eligibility

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

- be in an ongoing, exclusive and committed relationship with one another of mutual caring and support, in which each is responsible for the other's welfare and which is intended to continue indefinitely;
- be at least 18 years old and mentally competent to enter into a legal contract;
- reside together in a joint household for the preceding 6 consecutive months;
- share financial obligations of, and be jointly responsible for, the joint household;
- not be legally married to or legally separated from anyone else, and not be in a domestic partnership with anyone else; and
- not be blood relatives to a degree where marriage would be prohibited.

Child Eligibility

Your child is:

- your biological child; **or**
- your legally adopted child, including a child placed in your home for adoption by you as long as the child remains in your home and the adoption procedure has not been terminated (a legally adopted child will not qualify as a dependent if the child has reached age 18 as of the date of adoption or placement for adoption); **or**
- a stepchild for whom you or your spouse has full or joint custody or managing conservatorship; **or**
- any other child related to you by blood or marriage or for whom you or your spouse has court-appointed legal guardianship or managing conservatorship, who is living in your household on a substantially full-time basis, who you claim as a dependent for federal income tax purposes, and with whom you have a regular parent/child relationship.

In addition to meeting the above requirements, a child must also meet the following eligibility criteria:

- Unmarried; **and**
- Primarily dependent on you for support; **and**
- Less than age 19 if not a full-time student; **or**

** See *Eligible Retirees* for information regarding eligible retirees' ability to elect coverage for a domestic partner.

- Less than age 25 if a full-time student at an accredited educational institution taking nine or more hours per term; **or**
- Any age if he or she became physically or mentally incapable of self-support while enrolled in the Medical Plan and before reaching the applicable limiting age of 19 or 25 and continuously remains incapacitated and enrolled in the Medical Plan; **or**
- Any age if he or she was physically or mentally incapable of self-support on your date of employment with the Company, was enrolled in the Medical Plan as of your employment date and continuously remains incapacitated and enrolled in the Medical Plan.

In addition, your child must meet the Internal Revenue Code requirements for tax-free health coverage to be eligible for coverage in the Medical Plan.

By enrolling a dependent child, you represent that the individual satisfies these requirements. You must immediately drop coverage for a dependent child who no longer meets these requirements.

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

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

You may be required to provide evidence of dependent eligibility, such as, but not limited to, a marriage license, divorce decree, birth certificate, court order, adoption papers, certificate/affidavit of common-law marriage or proof of joint residency. Verification of a dependent child's full-time student status may be requested at age 19 and each year beyond age 19.

To continue coverage beyond age 19 for a child who is physically or mentally incapable of self-support, you must provide evidence of your child's incapacity to the applicable Claims Administrator. The application can be obtained by contacting the 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 graduates from college), the individual(s) who become(s) ineligible for coverage will be dropped from your coverage.

You must immediately report that any dependents 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 myHR Service Center that your dependent is no longer eligible.

If you do not inform the 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 elections (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 elections);

- 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, go to the myHR link on the Duke Energy Portal or contact the 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 – Eligible Employees

When You Are First Eligible

When you are eligible to enroll as an employee, you will make your Medical Plan elections 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 elections, contact the 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.

You may also decline coverage altogether.

During Annual Enrollment

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

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, 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).

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 election change occurs (see *Mid-Year Coverage 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 life event for which you can make a change in your Medical Plan elections (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.

Enrolling in the Medical Plan – Eligible Retirees

When You Are First Eligible

If you are an eligible retiree as described in *Eligible Retirees*, 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[††];
- Individual + Child(ren); or
- Individual + Family (spouse and child(ren))

You must make your election within 31 calendar days of becoming eligible for retiree coverage.

When you are eligible to enroll as a retiree, you can make your Medical Plan elections using an online enrollment tool. You will receive additional information about the online enrollment tool when you become eligible. You can also make your Medical Plan elections by contacting the myHR Service Center.

If you have any questions or need assistance in making your enrollment elections, contact the myHR Service Center.

[††] See *Eligible Retirees* for information regarding your ability to elect coverage for a domestic partner.

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 election 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 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 election changes are allowed.

Please refer to *During Annual Enrollment* and *Mid-Year Coverage Changes* for additional information.

During Annual Enrollment

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

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. When your employment terminates, you may reelect retiree coverage; however, unless you were represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA, you will not receive additional service credit for the time you worked as an active employee after your rehire date for purposes of determining your eligibility for or the amount of any Company contribution towards the cost of retiree medical coverage, either in the form of subsidized monthly coverage under the Medical Plan or Health Reimbursement Account benefits.

Cost of Coverage

Active Employees

If you are an active employee, 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 Web site.

Paying for Coverage as an Active Employee

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 a domestic partner under the Medical Plan is deducted on a pre-tax basis. On pay advice statements, the contribution amount for your coverage will appear as a pre-tax deduction and the contribution amount for your domestic partner will appear as imputed income.

While the Company subsidy amount for domestic partner coverage under the Medical Plan is the same as for spousal coverage, the subsidy amount for domestic partner coverage is reported each pay period as imputed income to the employee and is subject to applicable taxes.

Non-tobacco user discounts may be available for certain active employee Medical Plan coverage options. To qualify for applicable non-tobacco user discounts, you and all covered dependents must not have used tobacco products, including smokeless tobacco, during the 12 months prior to the effective date of your coverage. When you enroll, you will be asked to indicate if the non-tobacco user discount applies.

Non-Tobacco User Discount – Alternate Procedure for Active Employees in Certain Medical Plan Options

If you (or your covered dependent) are unable, due to a medical condition, to meet the requirements for the non-tobacco user discount (or if it is medically inadvisable for you to attempt to meet the requirements for the non-tobacco user discount), you may still apply to receive the discount by providing these two items:

1. A written statement from your (or your covered dependent's) physician stating that you (or your covered dependent) have a medical condition that makes it unreasonably difficult (or medically inadvisable) for you (or your covered dependent) to meet the requirements for the non-tobacco user discount. This statement should identify the health factor, explaining why the health factor makes it unreasonably difficult (or medically inadvisable) for you (or your covered dependent) to meet the requirements for the discount, and recommending a specific tobacco-cessation program that is appropriate for you (or your covered dependent), and
2. Either of the following:
   - A written statement from the recommended tobacco-cessation program stating that you (or your covered dependent) are either currently enrolled or that you (or your covered dependent) have completed the program within the last 12 months, or
   - If it is your initial year of claiming the discount in accordance with this procedure, a written certification from you that you (or your covered dependent) will enroll in the tobacco-cessation program recommended by your (or your dependent's) physician within the next three months.

In order to continue the non-tobacco user discount under this procedure, a new physician's statement and a new tobacco cessation program's statement will be required each year. In order

for you to qualify for the non-tobacco user discount, you and each of your covered dependents will have to meet the requirements for the discount or satisfy the alternate procedure.

If you would like to apply for the non-tobacco user discount under the alternate procedure, you should indicate at enrollment that you are a tobacco user and then contact the myHR Service Center to discuss remitting the information required under the alternate procedure. All information must be received within 31 calendar days of the date you become an eligible employee or, in the case of enrollment during a future annual enrollment period, by the deadline communicated in your annual enrollment materials. You will pay tobacco user rates until your alternate procedure application has been approved, at which time the non-tobacco user discount will be applied on a prospective basis as soon as administratively practicable.

Retirees

If you are an eligible retiree, the cost of your retiree coverage under the Medical Plan is based on the Medical Plan coverage option that you elect and the eligible dependent(s) you choose to cover. The portion of that cost that you must pay depends on multiple factors, including your date of hire, your date of termination and your retiree group. As described below, you may be eligible for a Company contribution towards the cost of retiree medical coverage, either in the form of subsidized monthly coverage under the Medical Plan or Health Reimbursement Account benefits. Information about contribution amounts is available through the YBR Web site.

If you were hired before January 1, 2009, you may be eligible for a Company contribution towards the cost of retiree medical coverage if you terminate employment after satisfying all applicable requirements. Your eligibility for Company contributions is governed by the eligibility rules in effect at the time of your date of 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 hired on or after January 1, 2009 (including most rehired employees) and you subsequently terminate your employment with the Company as an eligible retiree, you will not be eligible for a Company contribution toward the cost of retiree medical coverage and will be responsible for paying the full cost of any retiree coverage you elect under the Medical Plan, unless you are represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA, in which case the rules directly above for individuals hired before January 1, 2009 continue to apply to you.

If you are rehired on or after January 1, 2009 and you subsequently terminate your employment with the Company as an eligible retiree, you will be eligible for a Company contribution towards the cost of retiree medical coverage only if you satisfied the eligibility requirements for Company contributions toward the cost of retiree medical coverage in effect at the time of your previous 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. The rules described in this paragraph do not apply to individuals represented by IBEW 1347, IBEW 1393, USW 12049, USW 5541-06 or UWUA. If you are represented by one of these unions, the rules directly above for individuals hired before January 1, 2009 continue to apply to you.

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.
- You also have the option to pay contributions in advance for the quarter (three months); semi-annually or for the entire year. If you later drop coverage for any reason, your unused contributions will be refunded. Contact the myHR Service Center to set up alternate billing arrangements.
- 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 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 myHR Service Center.

If you would like to change your payment method, contact the myHR Service Center.

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 are two months behind but have been sending in partial payments, or
- you call the 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.

Reinstatement after non-payment is possible if you contact the 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.

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 elections as a newly eligible employee or retiree, coverage begins on the date you become eligible (assuming that you make your elections within 31 calendar days of becoming eligible). Deductions for your contributions (or payment for your

coverage, in the case of eligible retirees) begin as soon as administratively practicable following the date that you make your elections.

Mid-Year Coverage Changes

As a covered active employee or retiree, 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 that 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 myHR link located on the Duke Energy Portal or by contacting the myHR Service Center.

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

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 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 myHR Service Center within 31 calendar days of a loss of eligibility.

If you are eligible to make changes, the elections 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 marries or turns 19 and is not a full-time student)

- a QMCSO is received*
- your child dies

- You begin or end an international assignment scheduled for at least nine months
- 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
- You or your dependent's COBRA coverage from another employer expires
- You or your dependent becomes entitled to or loses Medicare or Medicaid*
- 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

When Mid-Year Election and Contribution Changes Are Effective

The following chart shows when coverage and contributions change if you notify the myHR Service Center of a work/life event within 31 calendar days of the event.

Election Change	Coverage	Contributions
Start or increase coverage	Coverage changes on the day the work/life event occurred (Event Date)	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*
Decrease or stop coverage (your elective decrease or coverage termination)**	Coverage changes on the first day of the month after your Election Date*	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*
Decrease coverage due to a covered individual becoming ineligible for coverage (for example, divorce, child is age 19 and not a full-time student)***	Coverage for individuals no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage (Event Date)	Changes to your contribution amounts are effective as soon as administratively practicable after your Election Date*

* Court Orders. 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 may also make an election change to cancel medical coverage for the child if the order requires the child's other parent to provide coverage.

* 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.

Election Change	Coverage	Contributions
* Your Election Date is the date you submit your election changes. **Does not include termination of employment. *** Does not include death. If you die, coverage ends on the date of your death.		

Situations Impacting Your 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 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 Insurance Plan or pay under the Sick Time Pay Benefit, you may be eligible for continued coverage under the Medical Plan. Contact the 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, your Medical Plan coverage will continue as long as you remain an eligible employee and pay any required contributions, and your coverage will be primary to Medicare.

If You Become Entitled to Medicare

If you are not actively at work and you become entitled to Medicare, you will be required to enroll in an option that coordinates with Medicare. Contact the 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 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 or as an eligible retiree;
- the last day of the month in which you cease to be an eligible employee, 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 the Company informs the Claims Administrator that you (while you are still eligible) are canceling Medical Plan coverage; or
- when 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. Medical Plan coverage will actually terminate, but will be reinstated retroactive to the coverage termination date if your 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.

When your coverage ends, you will receive a certificate of coverage that indicates the length of time you had coverage under the Medical Plan to the extent required by applicable law. You may need this certificate of coverage when enrolling in another plan. With this certificate, the time you were covered may be credited toward any pre-existing condition limitations in your new plan, provided you are enrolled in the new plan within 63 days of losing your Medical Plan coverage.

Benefits if You Die

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 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 myHR Service Center.

This provision applies even if your spouse 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 that any dependents 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 when your spouse/domestic partner either does or does not report a dependent's loss of eligibility within 31 calendar days of the loss of eligibility. To drop coverage for ineligible dependents, your spouse/domestic partner should go to the YBR Web site or contact the myHR Service Center.

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.

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, go to the myHR link on the Duke Energy Portal or contact the myHR Service Center.

If You Leave the Company

If your employment with the Company terminates, your coverage under the Medical Plan will end, unless you elect to continue coverage under COBRA or as an eligible retiree.

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

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 COBRA continuation coverage under the terms of COBRA, to maintain consistent administration, Duke Energy will apply the same rules to a domestic partner as to a spouse.

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,
- entitlement to Medicare, 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*.)

Bankruptcy Proceeding

If you are a retired employee and you or your eligible dependents lose coverage resulting from a bankruptcy proceeding against your Company, you may qualify for continuation coverage under COBRA.

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. The disability must last at least until the end of the 18-month period of continuation coverage.

You must notify the myHR Service Center in writing within the initial 18-month coverage period and within 60 days of the Social Security Administration's determination. Your verbal notice is not binding until confirmed in writing and the myHR Service Center receives a copy of the Social Security disability determination. You must also notify the 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, 2009, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2010, 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, 2012; or
- 18 months following your termination of employment - July 1, 2011

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2012 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 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 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;
- you become entitled to Medicare;
- you or an eligible dependent is determined to be disabled by the Social Security Administration

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

Duke Energy'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 will also 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 used 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 will also affect continued coverage under COBRA. You will be notified prior to 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. (If the other plan limits coverage of a pre-existing condition, COBRA coverage may be continued in certain circumstances).

Pre-existing Condition Limitation

If you become covered under another group medical plan and are affected by a pre-existing condition limitation under that plan, COBRA coverage may continue for that condition until you have satisfied the pre-existing condition limitation, as long as you remain within the COBRA period. When you are eligible for full benefits under your new plan, your COBRA coverage will be terminated.

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.

Medical Child Support Orders

If the Company receives notification that, as a result of a Qualified Medical Child Support Order, 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 may also sign claim forms and assign benefits to providers. The Claims Administrator will send notification of payment to 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 these guidelines:

- 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.
- 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
526 South Church Street
Charlotte, NC 28202
704-594-6200
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 plan number assigned to the Medical Plan is 502.

Funding

Benefits under the Medical Plan generally are provided from funds held by trustees. All Medical Plan claims except for post-retirement coverage for non-key employees are paid from the Duke Energy Corporation Welfare Benefits Trust VEBA I with Mellon Bank NA as trustee. Claims for post-retirement coverage for non-key employees are paid from the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II with Mellon Bank, NA as trustee. The address for Mellon Bank, NA is:

Mellon Bank, NA
One Mellon Bank Center
Pittsburgh, PA 15258

The Company may also provide benefits under the Medical Plan through insurance or from its general assets, and may also transfer assets from the 401(h) retiree account under the Duke Energy Corporation Master Retirement Trust to the Medical Plan to provide benefits for post-retirement coverage for non-key employees.

Plan Administrator

The Plan Administrator for the Medical Plan is the Duke Energy 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 the Claims Committee, which serves 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 and the Claims Committee may be contacted as follows:

Benefits Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285
704-594-6200

Claims Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285
704-594-6200

The Benefits Committee has appointed the Claims Administrators, which 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 can also obtain additional information by contacting the myHR Service Center.

The Benefits Committee, the Claims Committee and the Claims Administrators, 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 and the Duke Energy Corporation Post-Retirement Medical Benefits Trust VEBA II is the Duke Energy Investment Committee. The Chief Executive Officer of Duke Energy Corporation, or its delegate, appoints the Chairman of the Investment Committee, who in turn appoints the other members of the Investment Committee.

The Investment Committee oversees the maintenance and investment of plan assets for which it is named fiduciary, selects investment managers and collective investment funds, issues investment guidelines and objectives and monitors investment performance. The Investment Committee may be contacted through the following address:

Investment Committee
General Manager, Long Term Investments
Duke Energy Corporation
526 South Church Street, EC04Z
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:

Vice President, Legal
139 East Fourth Street - Room 25 ATII
P.O. Box 960
Cincinnati, OH 45201-0960
(513) 419-1851

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

Affiliated Employers of the Company That Have Adopted the Medical Plan

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

Claim Determination Procedures Under ERISA

The following are two different types of claims that may be made under the Medical Plan:

- claims for Medical Plan benefits; and
- 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 Medical Plan option (referred to as an "Eligibility or Enrollment Claim").

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 can also obtain additional information by calling the 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

Authority to decide an Eligibility or Enrollment Claim is assigned for initial claims to Duke Energy Human Resources, which is the Initial Claim Administrator. Human Resources has delegated its authority to the Hewitt Associates Benefits Determination Review Team. For denied claims on review, authority is assigned to the Duke Energy Claims Committee, which is the Denied Claim Reviewer.

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 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 the Benefit Determination Review Team within 90 days after the end of the plan year in which you are claiming eligibility/enrollment should have occurred.

The Benefits Determination Review Team 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 the Benefit Determination Review Team's control, it will notify you or your representative within 30 days after receiving the request. The extension notice will include 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 the Benefits Determination Review Team 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 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;
- 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 Medical Plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse determination on appeal;
- 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; and
- if the adverse determination is based on a medical necessity or experimental or investigative treatment, either a clinical or scientific explanation of the determination, applying the terms of the Medical Plan to your medical circumstances, or a statement that such clinical or scientific explanation will be provided free of charge upon request.

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.

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

Claims Committee
Duke Energy Corporation
400 South Tryon Street, ST06
Charlotte, NC 28285

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. Someone other than an individual involved in the initial determination, or a subordinate of such individual, will make the determination on appeal.

You will be notified regarding the decision on your claim within 60 days. The determination of your appeal will be in writing and, if adverse, will contain the following:

- the specific reasons for the adverse determination of your appeal;
- 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 statement regarding your right to sue under Section 502(a) of ERISA following an adverse determination on your appeal 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 or investigative treatment, either a clinical or scientific explanation of the determination, applying the terms of the Medical Plan to your medical circumstances, or a statement that such clinical or scientific explanation will be provided free of charge upon request; and
- the 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."

After completing all mandatory appeal levels, you have the right to further appeal adverse determinations by bringing a civil action under ERISA. Please refer to the *Statement of ERISA Rights* section below.

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 Appeals 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 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 Denied Claim Reviewers' decisions, interpretations and factual determinations controlling. Requests for information regarding individual claims, or 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.

Right to Change or Terminate the Medical Plan

Duke Energy 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 is also 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, 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 the Board of Directors, 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 insurance contracts, collective bargaining agreements and 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 insurance contracts and 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 person under 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* 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 summary plan description and the documents governing the Medical Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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 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 your 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 may also 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 myHR Service Center, if applicable, if you believe there is an error. If you move, marry, divorce, or gain a new child, or if your child marries, ceases to be a full-time student or is otherwise no longer an eligible dependent, contact the myHR Service Center as soon as possible. Certain work/life events allow you to change benefit elections that you previously made, but to do so, you must make the benefit election change within 31 calendar days of the work/life event.

A Final Note

Although this SPD describes the principal features of the Medical Plan that are generally applicable, it 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 be amended only by proper corporate action and not by oral or written communications about benefits under the Medical Plan.

Neither the Medical Plan, this SPD, nor your Medical Plan participation is an employment contract, and does 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.

Benefit Booklet
For Participants of
Duke Energy Medical Plan
for

BlueOPTIONS℠

EPO
(Blue Card Network)

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET

This benefit booklet describes benefits provided under the Duke Energy Medical Plan Exclusive Provider Organization (EPO) option (the *Plan*). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. **Please read this benefit booklet carefully.**

The benefit plan described in this booklet is an employee health benefit plan, subject to the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Conditions, limitations and exclusions are set forth in this benefit booklet for easy reference.

In the event of a conflict between this benefit booklet and the terms in the *Plan* document, the *Plan* document will control.

Quick Reference - Toll Free Phone Numbers, Web Site and Addresses

BCBSNC Web Site www.bcbsnc.com/members/duke-energy	To find a network provider by location or specialty, get general benefit information, search through our corporate medical policies to see medical criteria used to administer your benefits, obtain claim forms, access information about all the Blue Extras℠ discounts, "proof of coverage" portability certificates and more.
Member Services Web Site www.bcbsnc.com/members/duke-energy	To enroll in a safe and secure customer service web site to: Check claim status, verify benefits and eligibility or request a new ID card.
BCBSNC Customer Service 1-888-554-3202 8 a.m-8 p.m., Monday-Friday, except holidays	For questions regarding your benefits, claim inquiries and new ID card requests.
Magellan Behavioral Health 1-800-359-2422	For mental health and substance abuse inpatient and outpatient pre-certification. Note: You do not need certification for office visits.
Blue Card® PPO Program 1-800-810-BLUE (2583)	To find a participating provider.
Medical Claims Filing: *BCBSNC Claims Department* PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
Add/Remove Someone From Your Policy	Contact Duke Energy's myHR Service Center at 1-888-465-1300

Tips for Getting the Most Out of Your Health Care Benefits

1

Manage your out-of-pocket costs by managing the locations in which you receive care

Generally speaking, care received in a doctor's office is the most cost-effective for you, followed by hospital outpatient services. Hospital inpatient services often bear the highest cost. In addition, remember that in-network care (services from a BCBSNC participating provider who agrees to charge specified rates) will cost you less than similar care provided by an out-of-network provider. Know what your financial responsibility is before receiving care.

2

Pick a primary care physician

While our products do NOT require you to have a primary care physician, we strongly urge you to select and use one. A primary care physician informs you of your health care options, documents your care, and maintains your records for you. In addition, they save you time and unnecessary copayments by recommending appropriate specialists, coordinating your care with them, and informing them of things such as your medical history and potential drug interactions.

3

Understand your health care plan

The more you know about your benefits, the easier it will be to take control of your health. Let BCBSNC help you understand your plan and use it effectively through our customer-friendly Web site **(www.bcbsnc.com/members/duke-energy)**, toll free Customer Service line (1-888-554-3202).

MEMBER RIGHTS AND RESPONSIBILITIES

As a Blue Cross and Blue Shield of North Carolina member, you have the right to:

- Receive, upon request, information about Blue Options including its services, doctors, a benefit booklet, benefit summary and directory of in-network providers
- Receive courteous service from BCBSNC
- Receive considerate and respectful care from your in-network providers
- Receive the reasons for BCBSNC's denial of a requested treatment or health care service, including (upon request) an explanation of the Utilization Management criteria and treatment protocol used to reach the decision
- Receive (upon request) information on the procedure and medical criteria used by BCBSNC to determine whether a procedure, treatment, facility, equipment, drug or device is investigational, experimental or requires prior approval
- Receive accurate, reader-friendly information to help you make informed decisions about your health care
- Participate actively in all decisions related to your health care
- Discuss all treatment options candidly with your health care provider regardless of cost or benefit coverage
- Expect that measures will be taken to ensure the confidentiality of your health care information
- File a grievance and expect a fair and efficient appeals process for resolving any differences you may have with BCBSNC
- Be treated with respect and recognition of your dignity and right to privacy
- Voice complaints or appeals about the organization or the care it provides
- Make recommendations regarding the organization's members' rights and responsibilities policies

As a Blue Cross and Blue Shield of North Carolina member, you have the responsibility to:

- Present your ID card each time you receive services
- Give your doctor permission to ask for medical records from other doctors you have seen. You will be asked to sign a transfer of medical records authorization form.
- Read your Blue Options benefit booklet and all other Blue Options member materials
- Call BCBSNC Customer Services if you have a question or do not understand the material provided by BCBSNC
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, tell your doctor.
- Provide complete information about any illness, accident or health care issues to BCBSNC and providers
- Make and keep appointments for non-emergency medical care. If it is necessary to cancel an appointment, give the doctor's office adequate notice.
- Participate in understanding your health problems and the medical decisions regarding your health care
- Be considerate and courteous to Blue Options providers, their staff and BCBSNC representatives
- Notify your employer and BCBSNC if you have any other group coverage
- Notify your group administrator of any changes regarding dependents and marital status
- Protect your ID card from unauthorized use.

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WELCOME TO BLUE OPTIONS

Welcome to Blue Cross and Blue Shield of North Carolina's Blue Options plan!

As a *member* of the Blue Options plan, you will enjoy quality health care from a network of health care *providers* and easy access to *in-network specialists.* There are no benefits for services from *out-of-network providers.* You may verify a North Carolina *provider's* participation by calling Customer Services at the number given in "Whom Do I Call?"

You may receive, upon request, information about Blue Options, its services and *doctors*, including this benefit booklet with a benefit summary, and a directory of *in-network providers.*

How To Use Your Blue Options Benefit Booklet

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. Please read it carefully.

If you are trying to determine whether coverage will be provided for a specific service, you may want to review all of the following:

- "Summary of Benefits" to get an overview of your specific benefits, such as *deductible, coinsurance* and maximum amounts
- "*Covered Services*" to get more detailed information about what is covered and what is excluded from coverage
- "*Utilization Management*" for important information about when *prior review* and *certification* are required
- "What Is Not Covered?" to see general exclusions from coverage.

If you still have questions, you can call BCBSNC Customer Services at the number listed on your *ID Card* or in "Whom Do I Call?" and get further information.

As you read this benefit booklet, keep in mind that any word you see in **italics *(italics)* is a defined term** and will appear in "Definitions" at the end of this benefit booklet.

You will also want to review the following sections of this benefit booklet:

- "How Blue Options Works" explains the coverage levels available to you
- "What If You Disagree With A Decision?" explains the rights available to you when BCBSNC makes a decision and you do not agree.

Notice For Non-English Speaking *Members*

This benefit booklet contains a summary in English of your rights and benefits under the *Plan.* If you have difficulty understanding any part of this benefit booklet, contact BCBSNC Customer Service to obtain assistance.

AVISO PARA *AFILIADOS* QUE NO HABLAN INGLES

Este manual de beneficios contiene un resumen en inglés de sus derechos y beneficios que le ofrece el *Plan.* Si usted tiene dificultad en entender alguna sección de este manual, por favor llame al BCBSNC Customer Service para recibir ayuda.

WHOM DO I CALL?

BCBSNC Web Site

To view your claims, get *Plan* information, claim forms, health and wellness information, find a *doctor*, change your address, and request new *ID cards*, visit the BCBSNC Web site: **www.bcbsnc.com/members/duke-energy**

BCBSNC Customer Service

For questions about your benefits or claims, *ID card* requests, or to voice a complaint:

BCBSNC Customer Service ..... 1-888-554-3202 (toll free)

Mental Health And Substance Abuse Services

Companies who have signed contracts with BCBSNC administer these benefits. You must contact these vendors directly and request *prior review* for *inpatient* and *outpatient* services, except for *office visit* services and in *emergencies*. In the case of an *emergency*, please notify the vendor as soon as reasonably possible:

Magellan Behavioral Health ..... 1-800-359-2422 (toll free)

HealthLine Blue SM

To receive confidential, up-to-date health information 24 hours a day from specially trained nurses:

HealthLine Blue ..... 1-877-477-2424 (toll free)

COBRA Administrator

UMR ..... 1-800-523-3578 (toll free)

Prior Review

Some services require *prior review* and *certification* by BCBSNC. The list of these services may change from time to time. Please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed above for current information about which services require *prior review*. See "Prospective Review/*Prior Review*" in "*Utilization Management*" for information about the review process. To request *prior review*, call:

Providers ..... 1-800-214-4844 (toll free)
Members ..... 1-877-258-3334 (toll free)

HOW BLUE OPTIONS WORKS

In-Network Benefits

In-network providers are health care professionals and facilities that have contracted with BCBSNC, or *providers* participating in the BlueCard PPO program. *In-network providers* agree to limit charges for *covered services* to the *allowed amount*. If the billed amount is greater than the *allowed amount*, you are not responsible for the difference. You pay only the applicable *copayment* or *coinsurance*, and noncovered expenses. Your *in-network provider* is required to use the Blue Options network *hospital* where he/she practices, unless that *hospital* cannot provide the services you need.

Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the Blue Options program. Your *ID card* tells participating *providers* that you are a *member* of BCBSNC. When you use a *provider* participating in the local Blue Cross or Blue Shield Plan's *provider* network, benefits are provided at the *in-network copayment* or *coinsurance*.

You are not required to obtain any referrals to see an *in-network provider*. *In-network providers* will file claims for you. It is the *member's* responsibility to request *prior review* when necessary. *Prior review* is not required for an *emergency*.

The list of *in-network providers* may change from time to time. *In-network providers* are listed on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" Please note that *dentists* and orthodontists do not participate in the *provider* network.

Out-Of-Network Benefits

There are no benefits for services from *out-of-network providers*.

Out-Of-Network Benefit Exceptions

In an *emergency*, in situations where *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, or in continuity of care situations, *out-of-network* benefits will be paid at your *in-network copayment* or *coinsurance* and will be based on the billed amount. However, you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement. If you are billed by the *provider*, you will be responsible for paying the bill and filing a claim with BCBSNC.

For more information, see "*Emergency* Care," "Continuity Of Care" in "*Utilization Management*," and for information about BCBSNC's access to care standards, see the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy**. If you believe an *in-network provider* is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an *out-of-network provider*.

The Role Of A *Primary Care Provider (PCP)* Or *Specialist*

It is important for you to maintain a relationship with a *PCP*, who will help you manage your health and help you make decisions about your health care. If you change *PCPs*, be sure to have your medical records transferred, especially immunization records, to provide your new *doctor* with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care *provider* regardless of cost or benefit coverage. *PCPs* are trained to deal with a broad range of health care issues and can help you to determine when you need a *specialist*.

Please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service to be sure the *provider* you choose is available to be a *PCP*. You may want to confirm that the *provider* is in the network before receiving care.

If your *PCP* or *specialist* leaves the BCBSNC *provider* network and they are currently treating you for an ongoing special condition, see "Continuity Of Care" in "*Utilization Management*."

Members with serious or chronic disabling or life-threatening conditions may be allowed to select the *specialist* treating this condition as their *PCP*. The selected *specialist* would be responsible for providing and coordinating the *member's* primary and specialty care. The selection of a *specialist* under these circumstances shall be made under a treatment plan approved by the *specialist*, and BCBSNC, with notice to the *PCP* if applicable. A request may be denied where it is determined that the *specialist* cannot appropriately coordinate the *member's* primary and specialty care. To make this request or if you would like the professional qualifications of your *PCP* or *in-network specialist*, you may call BCBSNC Customer Service at the number given in "Whom Do I Call?"

Carry Your *Identification Card*

Your *ID card* identifies you as a Blue Options *member*. If any information on your *ID card* is incorrect or if you need additional cards, please visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC

Customer Service at the number listed in "Whom Do I Call?" **Be sure to carry your *ID card* with you at all times and present it each time you seek health care.**

Making An Appointment

Call the *provider's* office and identify yourself as a Blue Options *member*. Please ask the receptionist whether the *provider's* office is *hospital*-owned or operated or provides *hospital*-based services. Your *medical services* may be covered under *Outpatient* Services benefit. Your *provider* directory will also help you make this determination. *Provider* directories are available through the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or by calling BCBSNC Customer Service at the number given in "Whom Do I Call?" If you need nonemergency services after your *provider's* office has closed, please call your *provider's* office for their recorded instructions. You may also contact the nurse advice line, HealthLine Blue, for assistance.

If you cannot keep an appointment, call the *provider's* office as soon as possible. Charges for missed appointments, which *providers* may require as part of their routine practice, are not covered.

HealthLine Blue

You may call a HealthLine Blue nurse to assist you with medical questions, offer support, and send you free videotapes and brochures on health topics appropriate for your condition. *Members* may ask to speak with the same nurse on an ongoing basis. You may also visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** to search a library of current health topics, send secure messages to the HealthLine Blue nurses, learn about symptoms and medications and use tools that guide you through important health care decisions. See the number listed in "Whom Do I Call?" to speak to a HealthLine Blue nurse.

How To File A Claim

In-network providers will file claims for you. When you file a claim, mail the completed claim form for all *medical services*, including mental health and substance abuse services, to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

Blue Options covers only those services that are *medically necessary*. Also keep in mind as you read this section:

- **Certain services require *prior review* and *certification* in order for you to avoid a partial (penalty) or complete denial of benefits. General categories of services are noted below as requiring *prior review*. Also see "Prospective Review/*Prior Review*" in "*Utilization Management*" for information about the review process, and visit the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or call BCBSNC Customer Service to ask whether a specific service requires *prior review* and *certification*.**
- Exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "*Covered Services*." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "*Covered Services*," "Summary Of Benefits" and "What Is Not Covered?"
- You may also receive, upon request, information on the procedure and medical criteria used by BCBSNC to determine whether a procedure, treatment, facility, equipment, drug or device is *medically necessary* and eligible for coverage, *investigational* or *experimental*, or requires *prior review* and *certification* by BCBSNC. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. If you need more information about BCBSNC medical policies, see the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy**, or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Office Services

Care you receive as part of an *office visit* or house call is covered with a *copayment*, except as otherwise noted in this benefit booklet. Some *providers* may receive items such as supplies or drugs from third parties. In these cases, you may be billed directly by the supplier. Benefit payments for these services will be based on the type of supplier and how the services are billed.

The *Plan* also provides benefits for six nutritional visits per *benefit period*. Your benefits cover a total of six visits to an *in-network provider*. If you see an *in-network provider*, any applicable *copayment*, or *coinsurance* is waived for these six visits.

A *copayment* will not apply if you only receive services, such as allergy shots or other injections, and are not charged for an *office visit*.

Certain diagnostic imaging procedures, such as CT scans and MRIs, are subject to *coinsurance* and any applicable *deductible*, and may require *prior review* and *certification* or services will not be covered.

Some *doctors* or *other providers* may practice in *outpatient clinics* or provide *hospital*-based services in their offices. These services are covered as *Outpatient* Services and are listed as *Outpatient Clinic* Services in "Summary Of Benefits." The *provider* search on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** indicates which *providers* will collect *deductible* and *coinsurance*, or you can call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for this information.

Office Services Exclusion

- Services in free-standing surgical facilities, independent laboratories, therapy facilities or *outpatient hospital* departments.

Preventive Care

The *Plan* covers *preventive care* services that can help you stay safe and healthy.

Routine Physical Examinations

One routine physical examination and related diagnostic services per *benefit period* will be covered for each *member* age two and older.

Well-Baby And Well-Child Care

These services are covered for each *member* up to 24 months of age including periodic assessments and immunizations. Benefits are limited to six well-baby visits for *members* through 12 months old and three well-child visits for *members* 13 months to 24 months old.

Immunizations

The full series of standard immunizations recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians (AAFP) is covered.

Covered immunizations include the following:

- Tetanus, diphtheria, pertussis (Td/Tdap)
- Polio
- HiB
- Hepatitis A and B

- Measles-Mumps-Rubella (MMR)
- Influenza
- Pneumococcal vaccine
- Shingles
- Meningococcal vaccine.
- Human papillomavirus vaccine
- Chicken pox
- Rotavirus

Immunizations Exclusions

- Immunizations required for occupational hazard
- Immunizations required for international travel.

Gynecological Exam And Cervical Cancer Screening

The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and *doctor's* interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papilloma virus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

Ovarian Cancer Screening

For female *members* age 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered. A female *member* is considered "at risk" if she:

- Has a family history with at least one first-degree relative with ovarian cancer; and a second relative, either first-degree or second-degree with breast, ovarian, or nonpolyposis colorectal cancer; or
- Tested positive for a hereditary ovarian cancer syndrome.

Screening Mammograms

Beginning at age 35, one screening mammogram will be covered per female *member* per calendar year, along with a *doctor's* interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a *doctor* when a female *member* is considered at risk for breast cancer.

A female *member* is "at risk" if she:

- Has a personal history of breast cancer
- Has a personal history of biopsy-proven benign breast disease
- Has a mother, sister, or daughter who has or has had breast cancer, or
- Has not given birth before the age of 30.

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic *member* who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer. Increased/high risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered *surgery,* such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as Hemoccult screenings.

The *provider* search on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** can help you find office-based *providers* or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for this information.

Prostate Screening

One prostate specific antigen (PSA) test or an equivalent serological test will be covered per male *member* per calendar year. Additional PSA tests will be covered if recommended by a *doctor.*

Diagnostic Services

Diagnostic procedures such as laboratory studies, radiology services and other diagnostic testing, which may include electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs), help your *doctor* find the cause and extent of your condition in order to plan for your care.

Certain diagnostic imaging procedures, such as CT scans and MRIs, may require *prior review* and *certification* or services will not be covered.

Your *doctor* may refer you to a freestanding radiology center for these procedures. Separate benefits for interpretation of diagnostic services by the attending *doctor* are not provided in addition to benefits for that *doctor's* medical or surgical services, except as otherwise determined by BCBSNC.

Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure. See "Summary Of Benefits."

Bone Mass Measurement Services

The *Plan* covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if *medically necessary*. Qualified individuals include *members* who have any one of the following conditions:

- Estrogen-deficient and at clinical risk of osteoporosis or low bone mass
- Radiographic osteopenia anywhere in the skeleton
- Receiving long-term glucocorticoid (steroid) therapy
- Primary hyperparathyroidism
- Being monitored to assess the response or effect of commonly accepted osteoporosis drug therapies
- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

See *Outpatient* Services in the "Summary Of Benefits."

Emergency Care

The *Plan* provides benefits for *emergency services*. An *emergency* is the sudden and unexpected onset of a condition of such severity 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 an individual, or with respect to a pregnant woman the health of the pregnant woman or her unborn child, in serious jeopardy
- Serious physical impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Death

Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of *emergencies*.

What To Do In An *Emergency*

In an *emergency*, you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community emergency resources to obtain assistance in handling life-threatening *emergencies*. If you are unsure if your condition is an *emergency*, you can call HealthLine Blue; and a HealthLine Blue nurse will provide information and support that may save you an unnecessary trip to the emergency room.

Prior review is not required for *emergency services*. Your visit to the emergency room will be covered if your condition meets the definition of an *emergency*.

If you go to an emergency room for treatment of an *emergency*, your *coinsurance* will be the same, whether you use an *in-network* or *out-of-network provider*. When you receive these services from an *out-of-network provider*, benefits are based on the billed amount. However you may be responsible for charges billed separately by the *provider* which are not eligible for additional reimbursement, and you may be required to pay the entire bill at the time of service, and file a claim with BCBSNC.

Prior review and *certification* by BCBSNC are required for *inpatient* hospitalization and other selected services following *emergency services* (including screening and stabilization) in order to avoid a penalty. You may need to transfer to an *in-network hospital* once your condition has been *stabilized* in order to continue receiving *in-network* benefits.

Care Following *Emergency Services*

In order to receive *in-network* benefits for follow-up care related to the *emergency* (such as *office visits* or therapy once you left the emergency room or were discharged from the *hospital*), you must use *in-network providers*. Follow-up care related to the *emergency* condition is not considered an *emergency* and will be treated the same as a normal health care benefit.

Urgent Care

The *Plan* also provides benefits for *urgent care* services. When you need *urgent care*, call your *PCP*, a *specialist* or go to an *urgent care provider*. If you are not sure if your condition requires *urgent care*, you can call HealthLine Blue.

Urgent care includes services provided for a condition that occurs suddenly and unexpectedly and requires prompt diagnosis or treatment such that, in the absence of immediate care, the *member* could reasonably be expected to suffer chronic illness, prolonged impairment or the need for more serious treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female *members*. A *copayment* may apply for the *office visit* to diagnose pregnancy. If a *member* changes *providers* during pregnancy, terminates coverage during pregnancy, or the pregnancy does not result in delivery, one or more *copayments* may be charged for pre-natal services depending upon how the services are billed by the *provider*.

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 *doctor,* nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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*.

If the mother chooses a shorter stay, coverage is available for a *home health* visit for post-delivery follow-up care if received within 72 hours of discharge. In order to avoid a penalty, *prior review* and *certification* are required for *inpatient* stays extending beyond 48 hours following a vaginal delivery or 96 hours following a cesarean section. For information on *certification*, contact BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Termination of Pregnancy (Therapeutic Abortion)

Benefits for therapeutic abortion are available through the first 16 weeks of pregnancy for all female *members*.

Complications Of Pregnancy

Benefits for *complications of pregnancy* are available to all female *members* including dependent children. Please see "Definitions" for an explanation of *complications of pregnancy*.

Newborn Care

Inpatient newborn care of a well baby is covered under the mother's maternity benefits described above only during the first 48 hours after a vaginal delivery or 96 hours after delivery by cesarean section. This *inpatient* newborn care (well baby) requires only one admission *copayment* or *benefit period deductible* for both mother and baby. Benefits also include newborn hearing screening ordered by a *doctor* to determine the presence of permanent hearing loss.

For additional coverage of the newborn, whether *inpatient* (sick baby) or *outpatient*, the newborn must be enrolled for coverage as a dependent child within 31 days of the birth. At this time, the baby must meet the individual *benefit period deductible* if applicable, and *prior review* and *certification* are required to avoid a penalty.

Infertility And *Sexual Dysfunction* Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of *infertility* and *sexual dysfunction* for all *members* except dependent children.

Sterilization

This benefit is available for all *members* except dependent children. Sterilization includes female tubal ligation and male vasectomy.

Family Planning Exclusions

- The collection and storage of blood and stem cells taken from the umbilical cord and placenta for future use in fighting a disease
- Artificial means of conception, including, but not limited to, artificial insemination, in-vitro fertilization (IVF), ovum or embryo placement, intracytoplasmic sperm insemination (ICSI), and gamete intrafallopian tube placement (GIFT) and associated services
- Donor eggs and sperm
- Surrogate mothers
- Care or treatment of the following:
  - termination of pregnancy
  - contraceptive devices
  - reversal of sterilization
  - *infertility* and *sexual dysfunction* for dependent children.
- Elective abortion
- Treatment for *infertility* or reduced fertility that results from a prior sterilization procedure or when *infertility* or reduced fertility is the result of a normal physiological change such as menopause.

Facility Services

- *Outpatient* services received in a *hospital*, a *hospital*-based facility or an *outpatient clinic*.
- *Inpatient hospital* services. If you are admitted before the *effective date*, benefits will not be available for services received prior to the *effective date*. *Prior review* must be requested and *certification* must be obtained in advance from BCBSNC to avoid a penalty, except for maternity deliveries and *emergencies*. See "Maternity Care" and "*Emergency* Care."
- Surgical services received in an *ambulatory surgical center*
- *Covered services* received in a *skilled nursing facility*. *Prior review* must be requested and *certification* must be obtained in advance from BCBSNC to avoid a penalty. *Skilled nursing facility* services are limited to a day maximum per *benefit period*. See "Summary Of Benefits."

Other Services

Ambulance Services

The *Plan* covers services in a ground *ambulance* traveling:

- From a *member's* home or scene of an accident or *emergency* to a *hospital*
- Between *hospitals*
- Between a *hospital* and a *skilled nursing facility*

when such a facility is the closest one that can provide *covered services* appropriate to your condition. Benefits may also be provided for *ambulance* services from a *hospital* or *skilled nursing facility* to a *member's* home when *medically necessary*.

The *Plan* covers services in an air *ambulance* traveling from the site of an *emergency* to a *hospital* when such a facility is the closest one that can provide *covered services* appropriate to your condition and ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land. Nonemergency air *ambulance* services require *prior review* and *certification* or services will not be covered.

Ambulance Service Exclusion

- No benefits are provided primarily for the convenience of travel.

Blood

The *Plan* covers the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a *member's* own blood only when it is stored and used for a previously scheduled procedure.

Blood Exclusion

- Charges for the collection or obtainment of blood or blood products from a blood donor, including the *member* in the case of autologous blood donation.

Clinical Trials

The *Plan* provides benefits for participation in clinical trials phases II, III, and IV. Coverage is provided only for *medically necessary* costs of health care services associated with the trials, and only to the extent such costs

have not been or are not funded by other resources. The *member* must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of a life-threatening medical condition with services that are medically indicated and preferable for that *member* compared to non-*investigational* alternatives. In addition, the trial must:

- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical specialists
- Be approved by centers or groups funded by the National Institutes of Health, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

Clinical Trials Exclusions

- Clinical trials phase I
- Non-health care services, such as services provided for data collection and analysis
- *Investigational* drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

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:

- Accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- *Congenital* deformity, including cleft lip and cleft palate
- Disease due to infection or tumor, including tumors, cysts and exostosis
- Temporomandibular joint (TMJ) disease, including splinting and use of intra-oral *prosthetic appliances* to reposition the bones. Surgical benefits for TMJ disease are limited to *surgery* performed on the temporomandibular joint. If TMJ is caused by malocclusion, then benefits are provided for surgical correction of malocclusion if surgical management of the TMJ is *medically necessary*. Please have your *provider* contact BCBSNC before receiving treatment for TMJ.
- Impacted wisdom teeth.

The *Plan* provides benefits for extractions, crowns, bridges, and dentures for treatment of disease due to infection or tumor. For treatment of *congenital* deformity including cleft lip and cleft palate, benefits may be provided for dentures and orthodontic braces used to treat the condition.

When any of the conditions listed above require surgical correction, benefits for *surgery* will be subject to *medical necessity* 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*. *Prior review* and *certification* are required or services will not be covered, unless treatment is for an *emergency*.

Dental Treatment Excluded Under Your Medical Benefit

- Injury related to chewing or biting
- Preventive dental care, diagnosis or treatment of or related to the teeth or gums
- For disease due to infection or tumor:
  - Dental implants
  - Treatment for periodontal disease
  - Dental root form implants or root canals
  - Orthodontic braces
- For TMJ disease:
  - Dental implants
  - Treatment for periodontal disease

- Dental root form implants or root canals
- Crowns and bridges
- Extractions
- Dentures
- Orthodontic braces

- Replacement of crowns, bridges, dentures or in-mouth appliances, except as specifically stated as covered.

Durable Medical Equipment

Benefits are provided for *durable medical equipment* and supplies required for operation of equipment when prescribed by a *doctor*. Equipment may be purchased or rented at the discretion of the *Plan*. The *Plan* provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer *medically necessary*. Certain *durable medical equipment* requires *prior review* and *certification* or services will not be covered.

Durable Medical Equipment Exclusions

- Appliances that serve no medical purpose or that are primarily for comfort or convenience
- Repair or replacement of equipment due to abuse or desire for new equipment
- Rental or purchase of wheelchairs, hospital type beds, oxygen equipment (including oxygen), insulin pumps, Glucowatch and Autosensors, nebulizers and supplies related to the use of nebulizers and other *durable medical equipment*, subject to the following:
  - The equipment must be prescribed by a physician and needed in the treatment of an illness or injury and will be provided on a rental basis for the period of treatment. At our option, such equipment may be purchased. If the equipment is purchased, benefits will be payable for subsequent repairs necessary to restore the equipment to a serviceable condition; subsequent repairs due to abuse or misuse, as determined by BCBSNC, are not covered;
  - Benefits will be limited to the standard models, as determined by BCBSNC;
  - The *Plan* will pay benefits, if determined to be *medically necessary*, for ONE of the following: a manual wheelchair, a motorized wheelchair, or motorized scooter.

BCBSNC will pay benefits for the replacement of any *durable medical equipment* subject to the proof of change in a medical condition or that the equipment is no longer usable or repairable.

Eye Exams

The *Plan* provides coverage for one routine comprehensive eye examination per *benefit period*. Diagnosis and treatment of medical conditions of the eye, and drugs administered for purposes other than for a visual examination, are not considered to be part of a routine eye exam and are subject to the benefits, limitations and exclusions of the *Plan*.

Eye Exams Exclusion

- Fitting for contact lenses, glasses or other hardware.

Home Health Care

Home health care services, such as professional services of a *registered nurse (RN)* or *licensed practical nurse (LPN)* for visits totaling 8 hours a day, are covered by the *Plan* when the *member* is *homebound* due to illness or injury. *Home health* care requires *prior review* and *certification* or services will not be covered.

Home Health Care Exclusions

- Homemaker services, such as cooking and housekeeping
- Dietitian services or meals
- Services that are provided by a close relative or a member of your household.

Home Infusion Therapy Services

Home infusion therapy is covered for the administration of *prescription drugs* directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a *doctor*. These services must be provided under the supervision of an *RN* or *LPN*. Home infusion therapy requires *prior review* and *certification* or services will not be covered.

Hospice Services

- Your coverage provides benefits for *hospice* services for care of a terminally ill *member* with a life expectancy of six months or less. Services are covered only as part of a licensed health care program centrally coordinated through an interdisciplinary team directed by a *doctor* that provides an integrated set

of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families.

Hospice Services Exclusion

- Homemaker services, such as cooking, housekeeping, food or meals.

Medical Supplies

Coverage is provided for *medical supplies* such as ostomy supplies, catheters, oxygen and diabetic pump and pump supplies (needles, syringes, teststrips are covered under the pharmacy plan). To obtain *medical supplies*/equipment, please find a *provider* on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service.

Medical Supplies Exclusion

- *Medical supplies* not ordered by a *doctor* for treatment of a specific diagnosis or procedure.

Orthotic Devices

Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part, are covered if *medically necessary* and prescribed by a *provider*. Foot orthotics may be covered only when custom molded to the patient. Charges for custom built orthopedic shoes when *medically necessary* must be prescribed by a *doctor* and limited to two (2) pairs per calendar year. Orthotic devices for correction of *positional plagiocephaly*, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, are subject to a benefit limit.

Orthotic Devices Exclusions

- Pre-molded foot orthotics
- Over-the-counter supportive devices.

Private Duty Nursing

The *Plan* provides benefits for *medically necessary* private duty services of an *RN* or *LPN* when ordered by your *doctor*. *Prior review* must be requested and *certification* must be obtained or services will not be covered. These services are always subject to the *deductible* and *coinsurance*, regardless of location of service.

Private Duty Nursing Exclusion

- Services provided by a close relative or a member of your household.

Prosthetic Appliances

The *Plan* provides benefits for the purchase, fitting, adjustments, repairs, and replacement of *prosthetic appliances*. The *prosthetic appliances* must replace all or part of a body part or its function. The type of *prosthetic appliance* will be based on the functional level of the *member*. Therapeutic contact lenses may be covered when used as a corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a prescription change after cataract *surgery*. Certain *prosthetic appliances* require *prior review* and *certification* or services will not be covered.

Prosthetic Appliances Exclusions

- Dental appliances except when *medically necessary* for the treatment of temporomandibular joint disease
- *Cosmetic* improvements, such as implantation of hair follicles and skin tone enhancements
- Lenses for keratoconus or any other eye procedure except as specifically covered under the *Plan*.

Surgical Benefits

Surgical benefits by a professional or facility *provider* on an *inpatient* or *outpatient* basis, including pre-operative and post-operative care and care of complications, are covered. Surgical benefits include diagnostic *surgery*, such as biopsies, sigmoidoscopies and colonoscopies, and reconstructive *surgery* performed to correct *congenital* defects that result in functional impairment of newborn, adoptive and foster children.

Certain surgical procedures, including those that are potentially *cosmetic*, require *prior review* and *certification* or services will not be covered.

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter, may not be eligible for separate reimbursement. For information about coverage of multiple surgical procedures, please refer to BCBSNC's medical policies, which are on the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy**, or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Anesthesia

Your anesthesia benefit includes coverage for general, spinal block or monitored regional anesthesia ordered by the attending *doctor* and administered by or under the supervision of a *doctor* other than the attending surgeon or assistant at *surgery*. Separate benefits are not available for related services. Your coverage does not provide additional benefits for local anesthetics, which are covered as part of your surgical benefit.

Mastectomy Benefits

Under the Women's Health and Cancer Rights Act of 1998, the *Plan* provides for the following services related to mastectomy *surgery*:

- Reconstruction of the breast on which the mastectomy has been performed
- *Surgery* and reconstruction of the nondiseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive *surgery*
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Please note that the decision to discharge the patient following mastectomy *surgery* is made by the attending physician in consultation with the patient.

The benefits described above are subject to the same *deductibles*, *copayment* or *coinsurance* and limitations as applied to other medical and surgical benefits provided under the *Plan*.

Therapies

The *Plan* provides coverage for the following therapy services to promote the recovery of a *member* from an illness, disease or injury. A *doctor* or *other professional provider* must order these services.

Short-Term Rehabilitative Therapies

The following therapies are covered only for treatment of conditions that are expected to result in significant clinical improvement in a *member's* condition:

- Occupational therapy and/or physical therapy
- Speech therapy.

Benefits are limited to a visit maximum for occupational and/or physical therapy, speech therapy, chiropractic or any combination of these therapies. These visit limits apply in all places of service except *inpatient* (e.g., *outpatient*, office and home) regardless of the type of *provider* (chiropractors, other *doctors*, physical therapists). *Short-term rehabilitative therapy* received while an *inpatient* is not included in the *benefit period maximum*.

Other Therapies

The *Plan* covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Chemotherapy, including intravenous chemotherapy. For bone marrow or peripheral blood stem cell *transplants*, see "*Transplants*."

- Radiation therapy (including accelerated partial breast radiotherapy (breast brachytherapy). Breast brachytherapy is *investigational* but will be covered upon *prior review* and *certification*, based on meeting the American Society of Breast Surgeons (ASBS) criteria.)
- Limited treatment of autism, consisting of:

  (A) Therapy to develop interactive skills and skills necessary to perform the significant activities of daily living (eating, dressing, walking, bathing, toileting, and communicating). (The therapy must be performed by a licensed medical provider approved in advance. This therapy is not intended for schooling of an individual, even if the schooling requires a special environment. The provider must submit a treatment plan including the type of therapy to be administered, the goals, setting and periodic measures for the therapy, who will administer the therapy, and the patient's current ability to perform the desired results of the therapy. The treatment plan must be approved in advance by the Claims Administrator and updated quarterly with a report on the patient's condition, progress and future treatment plans.)

  (B) Care provided in accordance with the approved treatment plan by a non-licensed medical provider who is not a member of the patient's family, if the provider has been specifically trained to interact with the autistic patient and certified by a licensed medical provider as capable of working with the child. (This benefit is payable up to $50,000 during the lifetime of the patient, for the specific diagnosis of autism.)

  (C) Training and educational services provided by licensed medical providers (or non-licensed providers as described above) under an approved treatment plan for the parents or legal guardian of an autistic individual to teach the principles and practical applications of behavior modification (This benefit is payable up to $5,000 during the lifetime of the patient.)

Therapy Exclusions

- Cognitive therapy
- Speech therapy for stammering or stuttering.

Transplants

The *Plan* provides benefits for *transplants*, including *hospital* and professional services for covered *transplant* procedures. The *Plan* provides care management for *transplant* services and will help you find a *hospital* or Blue Quality Center for Transplants that provides the *transplant* services required. Travel and lodging expenses may be reimbursed, based on BCBSNC guidelines that are available upon request from a *transplant* coordinator.

For a list of covered transplants, call BCBSNC Customer Service at the number listed in "Whom Do I Call?" to speak with a *transplant* coordinator and request *prior review*. *Certification* must be obtained in advance from BCBSNC for all *transplant*-related services in order to assure coverage of these services.

If a *transplant* is provided from a living donor to the recipient *member* who will receive the *transplant*:

- Benefits are provided for reasonable and necessary services related to the search for a donor up to a maximum of $10,000 per *transplant*. However, other costs related to evaluation and procurement are covered up to the recipient *member's* coverage limit.
- Both the recipient and the donor are entitled to benefits of this coverage when the recipient is a *member*. Benefits provided to the donor will be charged against the recipient's coverage, if they don't have coverage for same elsewhere.

Some *transplant* services are *investigational* and not covered for some or all conditions or illnesses. Please see "Definitions" for an explanation of *investigational*.

Transplants Exclusions

- The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient *member*
- The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a *member*
- *Transplants*, including high dose chemotherapy, considered *experimental* or *investigational*
- Services for or related to the transplantation of animal or artificial organs or tissues.

Mental Health And Substance Abuse Services

The *Plan* provides benefits for the treatment by a of *mental illness* and substance abuse by a *hospital, doctor* or *other provider.* Your coverage for *in-network inpatient* and *outpatient* services is coordinated through Magellan Behavioral Health.

Separate visit limits and benefit maximums may apply. See information on *office visit* benefit maximums below.

Office Visit Services

Prior review by Magellan Behavioral Health is not required for *office visit* services. The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- *Medically necessary* biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

The following rules apply to mental health *office visit* benefit maximums:

- Each service provided by a mental health *provider* will count as one visit
- Any mental health therapy services provided by a non-mental health *provider* during the course of an *office visit* will count as one visit.

Outpatient Services

Covered *outpatient* services when provided in a mental health or substance abuse treatment facility include:

- Each service listed in this section under *office visit* services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).

Inpatient Services

Covered *inpatient* treatment services also include:

- Each service listed in this section under *office visit* services
- Semi-private room and board
- Detoxification to treat substance abuse.

Please note benefits for *inpatient* and *outpatient medical care* are limited to one visit per day.

How To Access Mental Health And Substance Abuse Services

Prior review by Magellan Behavioral Health is not required for *office visit* services. Although *prior review* is not required for *emergency* situations, please notify Magellan Behavioral Health of your *inpatient* admission as soon as reasonably possible. When you need *inpatient* or *outpatient* treatment, call a Magellan Behavioral Health customer service representative at the number listed in "Whom Do I Call?" The Magellan Behavioral Health customer service representative will refer you to an appropriate *in-network provider* and give you information about *prior review* and *certification* requirements.

Mental Health And Substance Abuse Services Exclusions And Limitations

- Psychoanalysis
- Counseling with relatives about a patient with *mental illness*, alcoholism, drug addiction or chemical dependency
- *Inpatient* confinements that are primarily intended as a change of environment
- Mental health services received in residential treatment facilities.

WHAT IS NOT COVERED?

Exclusions for a specific type of service are stated along with the benefit description in "*Covered Services.*" Exclusions that apply to many services are listed in this section. To understand all of the exclusions that apply, read "*Covered Services,*" "Summary Of Benefits" and "What Is Not Covered?" In addition, the *Plan* does not cover services, supplies, drugs or charges for:

- Provided by *out-of-network providers,* except when approved in advance by BCBSNC or in an *emergency* or *urgent care* situation
- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under the *Plan*
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- A dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group
- Dates of service received prior to the *member's effective da*te
- A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet.

A

Acupuncture and acupressure, unless services are provided by a medical *doctor*

Administrative charges billed by a *provider*, including charges for telephone consultations, failure to keep a scheduled visit, completion of claim forms, obtaining medical records, and late payments

Costs in excess of the ***allowed amount*** for services usually provided by one *doctor*, when those services are provided by multiple *doctors* or *medical care* provided by more than one *doctor* for treatment of the same condition

C

Claims not submitted to BCBSNC within 18 months of the date the charge was *incurred*, except in the absence of legal capacity of the *member*

Contraceptives, including oral and injectable contraceptives, contraceptive devices and long-term reversible contraceptives including, but not limited to, intrauterine devices and implanted hormonal contraceptives, solely prescribed for the purpose of contraception. These services are excluded at the request of your *employer.*

Convenience items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items

Cosmetic services, which include removal of excess skin from the abdomen, arms or thighs, and *surgery* for psychological or emotional reasons, except as specifically covered by the *Plan*

Services received either before or after the **coverage period** of the *Plan*, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination

Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a *doctor*.

D

Dental services provided in a *hospital*, except as specifically covered by the *Plan*, when a hazardous condition exists at the same time, or covered oral *surgery* services are required at the same time as a result of a bodily injury. Dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by the *Plan*.

The following **drugs:**

- *Prescription drugs* except as specifically covered by the *Plan*
- Injections by a health care professional of injectable *prescription drugs* which can be self-administered, unless medical supervision is required
- Clomiphene (e.g., Clomid), menotropins (e.g., Repronex) or other drugs associated with conception by artificial means

WHAT IS NOT COVERED? *(cont.)*

- *Experimental* drugs or any drug not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to *prescription drugs* used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been approved as effective in any one of the three nationally recognized drug reference guides:
    1. The American Medical Association Drug Evaluations
    2. The American Hospital Formulary Service Drug Information
    3. The United States Pharmacopoeia Drug Information.

E

Services primarily for **educational** purposes including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by the *Plan*

Side effects and complications of noncovered services, except for *emergency services* in the case of an ***emergency***

Services that would not be necessary if a noncovered service had not been received, except for *emergency services* in the case of an ***emergency***

The following **equipment**:

- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps
- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, pool or memberships to health clubs.

Experimental services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service, except as specifically covered by the *Plan*

F

*Routine **foot care*** that is palliative or *cosmetic*

G

Genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing

H

Hearing aids or examinations for the fitting of hearing aids except as specifically covered by the *Plan*

***Holistic** medicine* services

Hypnosis except when used for control of acute or chronic pain

I

Inpatient **admissions** primarily for the purpose of receiving diagnostic services or a physical examination. *Inpatient* admissions primarily for the purpose of receiving therapy services, except when the admission is a continuation of treatment following care at an *inpatient* facility for an illness or accident requiring therapy.

Investigational services in nature or obsolete, including any service, drugs, procedure or treatment directly related to an *investigational* treatment, except as specifically covered by the *Plan*

L

Services provided and billed by a **lactation consultant**

M

Services or supplies deemed not ***medically necessary***

O

Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a *member* or for treatment of **obesity**, except for surgical treatment of morbid obesity, or as specifically covered by the *Plan*

P

Care or services from a ***provider*** who:

- Cannot legally provide or legally charge for the services or services are outside the scope of the *provider's* license or certification

WHAT IS NOT COVERED? *(cont.)*

- Provides and bills for services from a licensed health care professional who is in training
- Is in a *member's* immediate family.

R

The following **residential care** services:

- Care in a self-care unit, apartment or similar facility operated by or connected with a *hospital*
- Domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities, except for substance abuse treatment, or any similar facility or institution.

Respite care except as specifically covered by the *Plan*

S

Services or supplies that are:

- Not performed by or upon the direction of a *doctor* or *other provider*
- Available to a *member* without charge.

Treatment or studies leading to or in connection with **sex changes or modifications** and related care

Sexual dysfunction unrelated to organic disease

Shoe lifts and shoes of any type unless part of a brace

T

The following types of **therapy**:

- Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
- *Maintenance therapy*
- Massage therapy.

Travel, whether or not recommended or prescribed by a *doctor* or other licensed health care professional, except as specifically covered by the *Plan*

V

The following **vision** services:

- Radial keratotomy and other refractive eye *surgery*, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens.
- Eyeglasses or contact lenses, except as specifically covered in "*Prosthetic Appliances*"
- Orthoptics, vision training, and low vision aids.

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind except for external nutrition administered exclusively via tube feeding as the sole source of nutrition. External nutrition products that are administered orally are excluded.

UTILIZATION MANAGEMENT

To make sure you have access to high quality, cost-effective health care, the *Plan* has a *utilization management* (*UM*) program. The *UM* program requires that certain health care services be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are *medically necessary*, provided in the proper setting and for a reasonable length of time. **The *Plan* will honor a *certification* to cover *medical services* or supplies under the *Plan* unless the *certification* was based on a material misrepresentation about your health condition or you were not eligible for these services under the *Plan* due to termination of coverage or nonpayment of premiums.**

Rights And Responsibilities Under The *UM* Program

Your *Member* Rights

Under the *UM* program, you have the right to:

- A *UM* decision that is timely, meeting applicable federal time frames
- The reasons for BCBSNC's denial of a requested treatment or health care service, including an explanation of the *UM* criteria and treatment protocol used to reach the decision
- Have a medical director from BCBSNC make a review of all denials of service that were based upon *medical necessity*
- Request a review of denial of benefit coverage through the *grievance* process
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf.

An authorized representative may act on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under the "*Utilization Management*" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

BCBSNC's Responsibilities

As part of all *UM* decisions, BCBSNC will:

- Provide you and your *provider* with a toll-free telephone number to call *UM* review staff when *certification* of a health care service is needed
- Limit what BCBSNC requests from you or your *provider* to information that is needed to review the service in question
- Request all information necessary to make the *UM* decision, including pertinent clinical information
- Provide you and your *provider* prompt notification of the *UM* decision consistent with the *Plan*.

In the event BCBSNC does not receive sufficient information to approve coverage for a health care service within specified time frames, BCBSNC will notify you in writing that benefit coverage has been denied. The notice will explain how you may pursue a review of the *UM* decision.

Prospective Review/*Prior Review*

The *Plan* requires that certain health care services receive *prior review* as noted in "*Covered Services*." These types of reviews are called prospective reviews. **If neither you nor your *provider* requests *prior review* and receives *certification*, this may result in a partial or complete denial of benefits. General categories of services with this requirement are noted in "*Covered Services*." You may also visit the BCBSNC Web site at www.bcbsnc.com/members/duke-energy or call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for a detailed list of these services. The list of services that require *prior review* may change from time to time.**

If the requested *certification* is denied, you have the right to appeal. See "What If You Disagree With A Decision?" for additional information. Certain services may not be covered *out-of-network*. See "*Covered Services*."

BCBSNC will make a decision on your request for *certification* within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated within three business days after BCBSNC receives all necessary information but no later than 15 days from the date BCBSNC received the request. If your request is incomplete, then within five days from the date BCBSNC received your request, BCBSNC will notify you and your *provider* of how to properly complete your request. BCBSNC may also take an extension of up to 15 days if additional information is needed. BCBSNC will notify you and your *provider* before the end of the initial 15-day period of the information needed and the date by which BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a decision within three business days. If BCBSNC does not approve benefit coverage of a health care service, BCBSNC will notify you and the *provider* by written or electronic confirmation.

Expedited Prospective Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. BCBSNC will notify you and your *provider* of its decision as soon as possible, taking into account the medical circumstances. BCBSNC will notify you and your *provider* of its decision within 72 hours after receiving the request. If BCBSNC needs additional information to process your expedited review, BCBSNC will notify you and your *provider* of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the time period specified for you to provide the information, whichever

is earlier, BCBSNC will make a decision on your request within a reasonable time but no later than 48 hours. An expedited review may be requested by callingBCBSNC Customer Service at the number given in "Whom Do I Call?"

Concurrent Reviews

BCBSNC will also review health care services at the time you receive them. These types of reviews are concurrent reviews.

BCBSNC will communicate concurrent review decisions to the *hospital* or other facility within three business days after BCBSNC receives all necessary information but no later than 15 days after the request. If BCBSNC does not provide *certification* of a health care service, BCBSNC will notify you, your *hospital's* or other facility's *UM* department and your *provider*. Written confirmation of the decision will also be sent to your home by U.S. mail.

For concurrent reviews, the *Plan* will remain responsible for *covered services* you are receiving until you or your representatives have been notified of the denial of benefit coverage.

Expedited Concurrent Review

You have a right to an expedited review when the regular time frames for a decision: (i) could seriously jeopardize your or your dependent's life, health, or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. If you request an extension of treatment that BCBSNC has already approved at least 24 hours before the current approved treatment ends, BCBSNC will notify you and your *provider* of its decision as soon as possible taking into account the medical circumstances, but no later than 24 hours after receiving the request.

Retrospective Reviews

BCBSNC also reviews the coverage of health care services after you receive them (retrospective reviews). Retrospective review may include a review to determine if services received in an emergency setting qualify as an *emergency*. BCBSNC will make all retrospective review decisions and notify you of its decision within a reasonable time but no later than 30 days from the date BCBSNC received the request. When the decision is to deny benefit coverage, BCBSNC will notify you and your *provider* in writing within five business days of the decision. All decisions will be based on *medical necessity* and whether the service received was a benefit under this *Plan*. BCBSNC may take an extension of up to 15 days if additional information is needed. Before the end of the initial 30-day period, BCBSNC will notify you of the extension, the information needed and the date by which BCBSNC expects to make a decision. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days. Services that were approved in advance by BCBSNC will not be subject to denial for *medical necessity* once the claim is received, **unless the *certification* was based on a material misrepresentation about your health condition or you were not eligible for these services under the *Plan* due to termination of coverage or nonpayment of premiums.** All other services may be subject to retrospective review and could be denied for *medical necessity* or for a benefit limitation or exclusion.

Care Management

Members with complicated and/or chronic medical needs may, solely at the option of BCBSNC, be eligible for care management services. Care management (or case management) encourages *members* with complicated or chronic medical needs, their *providers*, and the *Plan*, to work together to meet the individual's health needs and promote quality outcomes. To accomplish this, *members* enrolled in or eligible for care management programs may be contacted by BCBSNC or by a representative of BCBSNC. The *Plan* is not obligated to provide the same benefits or services to a *member* at a later date or to any other *member*. Information about these services can be obtained by contacting an *in-network PCP* or *in-network specialist* or by calling BCBSNC Customer Service.

Continuity Of Care

Continuity of care is a process that allows *members* with ongoing special conditions to continue receiving care from an *out-of-network provider*, when the *member's employer* changes plans or when their *provider* is no longer in the Blue Options network. If your *PCP* or *specialist* leaves the BCBSNC *provider* network and they are currently treating you for an ongoing special condition that meets BCBSNC continuity of care criteria, BCBSNC will notify you 30 days before the *provider's* termination, as long as BCBSNC receives timely notification from the *provider*. To be eligible for continuity of care, the *member* must be actively being seen by the *out-of-network provider* for an ongoing special condition and the *provider* must agree to abide by the *Plan's* requirements for continuity of care. An ongoing special condition means:

- in the case of an acute illness, a condition that is serious enough to require *medical care* or treatment to avoid a reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires *medical care* or treatment over a prolonged period of time;
- in the case of pregnancy, the second and third trimesters of pregnancy;
- in the case of a terminal illness, an individual has a medical prognosis that the *member's* life expectancy is six months or less.

The allowed transitional period shall extend up to 90 days, as determined by the *provider*, except in the cases of:

- scheduled *surgery*, organ transplantation, or *inpatient* care which shall extend through the date of discharge and post-discharge follow-up care or other *inpatient* care occurring within 90 days of the date of discharge; and

- second trimester pregnancy which shall extend through the provision of 60 days of postpartum care; and
- terminal illness which shall extend through the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be paid at the *member's in-network* benefit level. Continuity of care will not be provided when the *provider's* contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal. Please call BCBSNC Customer Service at the number listed in "Whom Do I Call?" for additional information.

Further Review Of *Utilization Management* Decisions

If you receive a *noncertification* as part of the *prior review* process, you have the right to request that the *Plan* review the decision through the *grievance* process. Refer to "What If You Disagree With A Decision?"

Delegated *Utilization Management*

For *UM* and the first level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services, Magellan Behavioral Health is responsible. Claims determinations and second level *grievance* review are provided by BCBSNC.

Evaluating New Technology

In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new medical technology, procedures and equipment. These policies allow BCBSNC to determine the best services and products to offer *members*. They also help BCBSNC keep pace with the ever-advancing medical field. Before implementing any new or revised policies, BCBSNC reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. BCBSNC then seeks additional input from *providers* who know the needs of the patients they serve.

WHAT IF YOU DISAGREE WITH A DECISION?

In addition to the *UM* program, the *Plan* offers a *grievance* procedure for *members*. *Grievances* include dissatisfaction with a claims denial or any decisions (including an appeal of a *noncertification* decision), policies or actions related to the availability, delivery or quality of health care services. If you have a *grievance*, you have the right to request that BCBSNC review the decision through the *grievance* process. The *grievance* process is voluntary and may be requested by the *member* or an authorized representative acting on the *member's* behalf with the *member's* written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps To Follow In The *Grievance* Process

For each step in this process, there are specified time frames for filing a *grievance* and for notifying you or your *provider* of the decision. The review must be requested in writing, within 180 days of a denial of benefit coverage (the initial claim denial or the first level *grievance* review decision).

Any request for review should include:

- Employee's ID number
- Employee's name
- Any other information that may be helpful for the review.
- Patient's name
- The nature of the *grievance*

To request a form to submit a request for review, visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

All correspondence related to a request for a review through BCBSNC's *grievance* process should be sent to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

In addition, members may also receive assistance with *grievances* from the Managed Care Patient Assistance Program by contacting:

Managed Care Patient Assistance Program
9001 Mail Service Center
Raleigh, NC 27699-9001
Tel: (919) 733-6272
Tel (toll free in NC): 1-866-867-6272
Email: MCPA@ncdoj.gov

Following such request for review, a review will be conducted by BCBSNC, by someone who is neither the individual who made the original claims denial that is the subject of the *grievance*, nor the subordinate of such individual. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations with respect to whether a particular treatment, drug or other item is *experimental, investigational*, or not *medically necessary* or appropriate, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

First Level Grievance Review

BCBSNC will provide you with the name, address and phone number of the *grievance* coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials. For *grievances* concerning quality of health care, an acknowledgement will be sent by BCBSNC within five business days.

Although you are not allowed to attend a first level *grievance* review, BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level *Grievance* Review

Since the *Plan* is subject to *ERISA*, the first level *grievance* review is the only level that you must complete before you can pursue your *grievance* in an action in federal court.

Otherwise, if you are dissatisfied with the first level *grievance* review decision, you have the right to a second level *grievance* review. Second level *grievances* are not allowed for benefits or services that are clearly excluded by this benefit booklet or quality of care complaints. Within ten business days after BCBSNC receives your request for a second level *grievance* review, the following information will be given to you:

- Name, address and telephone number of the *grievance* coordinator
- A statement of your rights, including the right to:

WHAT IF YOU DISAGREE WITH A DECISION? *(cont.)*

- request and receive from BCBSNC all information that applies to your case
- attend the second level *grievance* review meeting
- present your case to the review panel
- submit supporting material before and at the review meeting
- ask questions of any member of the review panel
- be assisted or represented by a person of your choosing, including a family member, an *employer* representative, or an attorney
- pursue other voluntary alternative dispute resolution options.

The second level review meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level *grievance* review request. You will receive notice of the meeting date and location at least 15 days before the meeting. You have the right to a full review of your *grievance* even if you do not attend the meeting. A written decision will be issued to you within five business days of the review meeting.

Notice Of Decision

If any claim (whether expedited or nonexpedited) shall be wholly or partially denied at either the first level *grievance* or the second level *grievance* review, a written notice shall be provided to the *member* worded in an understandable manner and shall set forth:

- The specific reason(s) for the denial
- Reference to the specific the *Plan* provisions on which the decision is based
- A statement that the *member* is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the *member's* claim for benefits
- If applicable, a statement describing any voluntary appeals procedures and the *member's* right to receive information about the procedures as well as the *member's* right to bring a civil action under Section 502(a) of *ERISA* following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request
- If the decision is based on *medical necessity* or *experimental* treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *member's* medical circumstances, or a statement that such explanation will be provided without charge upon request; and
- The following statement: "You 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."

Expedited Review

You have the right to a more rapid or expedited review of a denial of coverage if a delay: (i) would reasonably appear to seriously jeopardize your or your dependent's life, health or ability to regain maximum function; or (ii) in the opinion of your *provider*, would subject you or your dependent to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling BCBSNC Customer Service at the number given in "Whom Do I Call?" An expedited review will take place in consultation with a medical *doctor*. All of the same conditions for a first level or second level *grievance* review apply to an expedited review, except that the review meeting will take place through a conference call or through written communication. BCBSNC will communicate the decision by phone to you and your *provider* as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

After requesting an expedited review, the *Plan* will remain responsible for covered health care services you are receiving until you have been notified of the review decision.

Correspondence related to a request for a review through the *Plan's grievance* process should be sent to:

BCBSNC
Customer Services
PO Box 2291
Durham, NC 27702-2291

Delegated Appeals

Magellan Behavioral Health is responsible for the first level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services. Please forward written *grievances* to:

Magellan Behavioral Health
Appeals Department
PO Box 1619

Alpharetta, GA 30009

Second level *grievance* review for *inpatient* and *outpatient* mental health and substance abuse services is provided by BCBSNC

ADDITIONAL TERMS OF YOUR COVERAGE

Benefits To Which *Members* Are Entitled

The benefits described in this benefit booklet are provided only for *members*. These benefits and the right to receive payment cannot be transferred to another person. At the option of the *Plan*, payment for services will be made to the *provider* of the services, or the *Plan* may choose to pay the *participant*.

If a *member* resides with a custodial parent or legal guardian who is not the *participant*, the *Plan* will, at its option, make payment to either the *provider* of the services or to the custodial parent or legal guardian for services provided to the *member*. If the *participant* or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the *provider*.

Benefits for *covered services* specified in the *Plan* will be provided only for services and supplies that are performed by a *provider* as specified in the *Plan* and regularly included in the *allowed amount*. BCBSNC establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under the *Plan*.

Any amounts paid by the *Plan* for noncovered services or that are in excess of the benefit provided under your Blue Options coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a *member's* future claim payment. This can result in a reduction or elimination of future claims payments. Amounts paid by the *Plan* for work-related accidents, injuries, or illnesses covered under state workers' compensation laws will be recovered upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the *member*, the employer or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

Providers are independent contractors, and they are solely responsible for injuries and damages to *members* resulting from misconduct or negligence.

BCBSNC's Disclosure Of Protected Health Information (PHI)

BCBSNC takes your privacy seriously and handles all PHI as required by state and federal laws and regulations and accreditation standards. BCBSNC has developed a privacy notice that explains the procedures. To obtain a copy of the privacy notice, visit the BCBSNC Web site at **www.bcbsnc.com/members/duke-energy** or call BCBSNC Customer Service at the number listed in "Whom Do I Call?"

Administrative Discretion

BCBSNC has the authority to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning coverage of services, care, treatment or supplies, and reasonableness of charges. BCBSNC medical policies are guides considered when making coverage determinations.

Provider Reimbursement

BCBSNC has contracts with certain *providers* of health care services for the provision of, and payment for, health care services provided to all *members* entitled to health care benefits. BCBSNC's payment to *providers* may be based on an amount other than the actual charges, including without limitation, an amount per confinement or episode of care, agreed upon schedule of fees, or other methodology as agreed upon by BCBSNC and the *provider*. Under certain circumstances, a contracting *provider* may receive payments from BCBSNC greater than the charges for services provided to an eligible *member*, or BCBSNC may pay less than charges for services, due to negotiated contracts. The *member* is not entitled to receive any portion of the payments made under the terms of contracts with *providers*. The *member's* liability when defined as a percent of charge shall be calculated based on the lesser of the *allowed amount* or the *provider's* actual charge for *covered services* provided to a *member*.

Services Received Outside Of North Carolina

Your *ID card* gives you access to participating *providers* outside the state of North Carolina through the BlueCard program. Your *ID card* tells participating *providers* that you are a *member* of BCBSNC. By taking part in this program, you may receive discounts from out-of-state *providers* who participate in the BlueCard program.

When you obtain health care services through the BlueCard program outside the area in which the BCBSNC network operates, the amount you pay toward such *covered services*, such as *deductibles*, *copayments* or *coinsurance*, is usually based on the lesser of:

- The billed charges for your *covered services*, or
- The negotiated price that the out-of-state Blue Cross and/or Blue Shield licensee ("Host Blue") passes on to BCBSNC.

This "negotiated price" can be:

- A simple discount which reflects the actual price paid by the Host Blue
- An estimated price that factors in expected settlements, withholds, contingent payment arrangements, or other nonclaims transactions, with your health care *provider* or with a group of *providers*
- A discount from billed charges that reflects the **average** expected savings with your health care *provider* or with a group of *providers*. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

The estimated or average price may be adjusted in the future to correct for over- or under-estimation of past prices. However, the amount you pay is considered a final price.

Should any state enact a law that mandates liability calculation methods that differ from the usual BlueCard program method or requires a surcharge, your required payment for services in that state will be based upon the method required by that state's law.

Right Of Recovery Provision

Immediately upon paying or providing any benefit under the *Plan*, the *Plan* shall be subrogated to all rights of recovery a *member* has against any party potentially responsible for making any payment to a *member* due to a *member's* injuries, illness or condition, to the full extent of benefits provided or to be provided by the *Plan*.

In addition, if a *member* receives any payment from any potentially responsible party as a result of an injury, illness or condition, the *Plan* has the right to recover from, and be reimbursed by, the *member* for all amounts the *Plan* has paid and will pay as a result of that injury or illness, up to and including the full amount the *member* receives from all potentially responsible parties. The *member* agrees that if the *member* receives any payment from any potentially responsible party as a result of an injury or illness, the *member* will serve as a constructive trustee over the funds for the benefit of the *Plan*. Failure to hold such funds in trust will be deemed a breach of the *member's* fiduciary duty to the *Plan*.

Further, the *Plan* will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a *member* receives from any third party, any third party's insurer or any other source as a result of the *member's* injuries. The lien is in the amount of benefits paid by the *Plan* for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a *member* due to a *member's* injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The lien can be filed with or enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the *Plan* including, but not limited to, the *member*; the *member's* representative or agent; responsible party; responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the *Plan*.

The *member* acknowledges that the *Plan's* recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the *Plan* before any other claim for the *member's* damages. The *Plan* shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the *Plan* will result in a recovery to the *member* which is insufficient to make the *member* whole or to compensate the *member* in part or in whole for the damages sustained. It is further understood that the *Plan* will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the *Plan* is not required to participate in or pay court costs or attorney fees to any attorney hired by the *member*.

The terms of this entire right of recovery provision shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the *member* identifies the medical benefits the *Plan* provided. The *Plan* is entitled to recover from **any and all** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The *member* acknowledges that BCBSNC has been delegated authority by the *Plan Administrator* to assert and pursue the right of subrogation and/or reimbursement on behalf of the *Plan*. The *member* shall fully cooperate with BCBSNC's efforts to recover benefits paid by the *Plan*. It is the duty of the *member* to notify BCBSNC in writing of the *member's* intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the *member*. The *member* shall provide all information requested by BCBSNC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as BCBSNC may reasonably request.

The *member* shall do nothing to prejudice the *Plan's* recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by the *Plan*.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the *member* and the *Plan* agree that the *Plan Administrator* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The *member* agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as BCBSNC may elect. Upon receiving benefits under the *Plan*, the *member* hereby submits to each such jurisdiction, waiving whatever rights may correspond to the *member* by reason of the *member's* present or future domicile.

Notice Of Claim

The *Plan* will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that *covered services* have been provided to a *member*. If the *member* files the claim, written notice must be given to BCBSNC within 18 months after the *member incurs* the *covered service*, except in the absence of legal capacity of the *member*. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

ADDITIONAL TERMS OF YOUR COVERAGE *(cont.)*

Notice Of Benefit Determination

BCBSNC will provide an explanation of benefits determination to the *member* or the *member's* authorized representative within 30 days of receipt of a notice of claim if the *member* has financial liability on the claim other than a *copayment* (unless your *Plan* has chosen to provide an explanation of benefits for additional claims where the *member* does not have a financial liability other than a *copayment*). BCBSNC may take an extension of up to 15 additional days to complete the benefits determination if additional information is needed. If BCBSNC takes an extension, BCBSNC will notify the *member* or the *member's* authorized representative of the extension and of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days.

Such notice will be worded in an understandable manner and will include:

- The specific reason(s) for the denial of benefits
- Reference to the benefit booklet section on which the denial of benefits is based
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed
- A description of the review procedures and the time limits applicable to such procedures, including the *member's* right to bring a civil action under Section 502(a) of *ERISA* following a denial of benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request
- If the denial of benefits is based on *medical necessity* or *experimental* treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the health benefit plan to the *member's* medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of a denial of benefits involving *urgent care*, a description of the expedited review process available to such claims.

Upon receipt of a denial of benefits, you have the right to file a *grievance* with BCBSNC. See "What If You Disagree With A Decision?" for more information.

Limitation Of Actions

Since the *Plan* is subject to *ERISA*, you must only exhaust the first level *grievance* review process following the Notice of Claim requirement. Please see "What If You Disagree With A Decision?" for details regarding the *grievance* review process. No legal action may be taken later than three years from the date *covered services* are *incurred*. However, if you are authorized to pursue an action in federal court under *ERISA*, and you choose to pursue a second level *grievance* review, the three-year limitation is temporarily suspended until that review has been resolved.

Coordination Of Benefits (Overlapping Coverage)

If a *member* is also enrolled in another group health plan, the *Plan* may coordinate benefits with the other plan. Coordination of benefits (COB) means that if a *member* is covered by more than one insurance plan, benefits under one plan are determined before the benefits are determined under the second plan. The plan that determines benefits first is called the primary plan. The other plan is called the secondary plan. Benefits paid by the secondary plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service.

Most group health insurance plans include a COB provision. The rules used to determine which plan is primary and secondary are listed in the following chart. The "participant" is the person who is signing up for health insurance coverage.