



Prescription Drug Program Guide for the Duke Energy Active Medical Plan

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SECTION 1 – WELCOME

The Duke Energy Active Medical Plan (“Medical Plan”) options include outpatient prescription drug coverage currently administered by CVS Caremark. CVS Caremark works with Duke Energy Corporation (“Duke Energy”) (individually or collectively referred to with its affiliated companies as the “Company,” as appropriate) to help you improve your health and make informed health care decisions, as well as save money on your prescription drugs.

Your prescription drug program benefits through CVS Caremark include the following features:

- The CVS Caremark retail network consists of more than 64,000 participating retail pharmacies.
- Your long-term prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy.
- Online resources are available at www.Caremark.com to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- You can reach CVS Caremark Customer Service representatives, 24 hours a day, 7 days a week at 888-797-8912. Pharmacists are also available around the clock for medication consultations.

CVS Caremark will help protect your privacy as follows:

- CVS Caremark employees follow detailed ethical standards and a comprehensive Code of Conduct regarding your personal health information.
- CVS Caremark pharmacists follow a professional Code of Ethics.

SECTION 2 – HOW THE PROGRAM WORKS

Prescription Drug Coverage under the Health Savings Plan (HSP) Options

Because you are enrolled in a Health Savings Plan (HSP) option under the Medical Plan, you pay 100% of CVS Caremark's negotiated price for your prescription drug purchases (other than preventive medications, as described below) at retail pharmacies and through the CVS Caremark Mail Service Pharmacy until you meet the applicable Medical Plan annual deductible under your HSP option¹.

If you use a pharmacy that is participating in the CVS Caremark retail network, once you meet your applicable annual deductible, the HSP option pays eligible prescription drug expenses at 80% coinsurance and you pay 20% until you reach the applicable Medical Plan annual out-of-pocket maximum under the HSP option. If you use a pharmacy that is not participating in the CVS Caremark retail network, once you meet your applicable annual deductible, the HSP option pays eligible prescription drug expenses at 60% coinsurance and you pay 40% until you reach the applicable Medical Plan annual out-of-network, out-of-pocket maximum under the HSP option. The applicable annual out-of-pocket maximum under the HSP option is a combined out-of-pocket maximum that applies to both medical and prescription drug expenses under the Medical Plan. After you reach the applicable annual out-of-pocket maximum, the HSP option pays 100% of your eligible prescription drug purchases for the remainder of the calendar year.

If you use any medications on a long-term basis, ordering your medications through the CVS Caremark Mail Service Pharmacy may still help you maximize savings.

Remember: Under the HSP option, your eligible medical expenses and your eligible prescription drug purchase amounts apply to the HSP option's annual deductible and you pay 100% of your eligible expenses (excluding certain preventive care services and preventive medications) until you reach the deductible.

As you make prescription drug purchases for each covered individual, the receipts you receive can help you track your progress toward meeting the annual deductible. You may also call CVS Caremark Customer Service to determine the portion of the deductible that has been satisfied to date.

¹ For in-network benefits under the HSP option, you must satisfy an annual individual deductible if only you are covered or an annual family deductible if one or more of your eligible dependents also is covered.

Filling Your Prescription at a Pharmacy Participating in the CVS Caremark Retail Network

You can fill a prescription for up to a 30-day supply at any of over 64,000 retail pharmacies participating in the CVS Caremark retail network. You will simply show your CVS Caremark prescription ID card at the time of your purchase. You will pay 100% of your non-preventive prescription drug purchases until you meet the applicable Medical Plan annual deductible under your HSP option, after which you pay a coinsurance amount. Once you meet the applicable Medical Plan annual out-of-pocket maximum under your HSP option, the Medical Plan pays for your eligible prescription drug purchases at 100%.

- If you don't identify yourself to the pharmacist as a CVS Caremark participant, or if you go to a pharmacy that is not participating in the CVS Caremark retail network, you will have to pay the full price for non-preventive prescription drug purchases, even if you have already met the applicable Medical Plan annual deductible or annual out-of-pocket maximum under your HSP option, when you pick up the prescription and then submit a paper claim to CVS Caremark for reimbursement. You will be reimbursed based on the CVS Caremark negotiated price for the medication, less any required deductible and coinsurance. Retail pharmacies that participate in the CVS Caremark retail network fill prescriptions at an agreed upon discounted price. When you fill prescriptions at a non-participating retail pharmacy, or do not identify yourself as a CVS Caremark participant, you may be charged a price higher than the negotiated price and the result is a higher cost prescription to you.
- If you make a non-preventive prescription drug purchase at a pharmacy that is participating in the CVS Caremark retail network, do not identify yourself as a CVS Caremark participant by presenting your CVS Caremark prescription ID card and are required to pay full price for the non-preventive prescription drug purchase, generally, you have up to 14 days from the time your prescription was purchased to return to the pharmacy, present your CVS Caremark prescription ID card and ask the pharmacist to submit the order using the original dispensing date. Please confirm at the time you make your purchase that you can return to have your purchase re-processed. You may be entitled to a refund for the difference between the full price and your applicable deductible and coinsurance. This process will eliminate your need to submit a paper claim to CVS Caremark for reimbursement.

Using the CVS Caremark Maintenance Choice™ Program

Generally, a long-term (maintenance) medication is one that you take on a long-term basis such as those used for diabetes, asthma, high blood pressure, high cholesterol or birth control. If you are taking a long-term (maintenance) medication, you may request that your doctor prescribe 90-day supplies, plus refills as appropriate (three refills maximum) instead of 30-day supplies. Under CVS Caremark's Maintenance Choice program, if you choose to receive 90-day supplies, you must fill your prescription through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy near you.

Fill limit for long-term medications

The Medical Plan allows three 30-day fills of long-term medications at any pharmacy that participates in the CVS Caremark retail network. After that, the Medical Plan will cover long-term medications only if you have 90-day supplies filled through the CVS Caremark Mail

Service Pharmacy or at a CVS retail pharmacy at the applicable 90-day supply coinsurance amount. If you do not use the CVS Caremark Mail Service Pharmacy or a CVS retail pharmacy after the third fill, you will pay 100% of the retail price of the long-term medication.

Before you reach your 30-day fill limit and your out-of-pocket cost increases, CVS Caremark will contact you to help you get started with Maintenance Choice. CVS Caremark will help you get a 90-day prescription from your doctor so you can choose to fill it through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy.

If you will be obtaining your own prescription, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum).

The list of long-term medications that are part of the Maintenance Choice program is subject to change at any time. Visit www.Caremark.com to find out whether your medication is considered a long-term medication and whether it is affected by any Medical Plan limits, or you may call CVS Caremark directly for more information.

Process for Mail Order Medications

To receive your long-term medications from the CVS Caremark Mail Service Pharmacy, complete the CVS Caremark Mail Service Order Form and send it to CVS Caremark, along with your original prescription(s) and the appropriate co-insurance amount for each prescription. Be sure to include your original prescription, as photocopies are not accepted. Call CVS Caremark to help you determine the required co-insurance amount for your prescription drug purchase. If you established an HSA and sufficient funds are in your account, you may use your HSA debit card or checkbook to pay for your CVS Caremark Mail Service Pharmacy purchases.

You can find a mail order form at www.Caremark.com, or you can call CVS Caremark Customer Service at 888-797-8912 to request a form. You also can find a mail order form on the Duke Energy Portal. Please complete the form, and mail it, along with the original prescription, to CVS Caremark. Keep a copy of the prescription for your records and allow a minimum of 10 to 14 business days for delivery.

Send mail order prescriptions to:
CVS Caremark Mail Service Pharmacy
P.O. Box 2110
Pittsburgh, PA 15230-2110

Please note: You must mail in a CVS Caremark Mail Service Order Form the first time you request a new prescription through mail service. You cannot use the available automated refill service until after your first prescription order has been processed by CVS Caremark.

You can also get started using the CVS Caremark Mail Service Pharmacy with FastStart[®]. FastStart[®] offers three convenient options for filling prescriptions for long-term medications:

Option 1: Internet

- a) Go to www.Caremark.com and sign in or register (if necessary). Click on “Start a New Prescription” and then click on “FastStart”.
- b) Fill in your:
 - Plan ID number (on your CVS Caremark prescription ID card)

- Prescription name
 - Doctor's name and phone number
 - Mailing address
 - Payment information
- c) CVS Caremark will contact your doctor to get a prescription for you.

Option 2: Phone

- a) Call FastStart toll-free at 800-875-0867.
- b) Provide your:
- Plan ID number (on your CVS Caremark prescription ID card)
 - Prescription name
 - Doctor's name and phone number
 - Mailing address
 - Payment information
- c) The CVS Caremark representative will contact your doctor and fill out the order form for you.

Option 3: Physician

- a) Give your doctor's office the toll-free FastStart physician number, 800-378-5697, and ask your doctor to call in the prescription for a 90-day supply.
- b) To expedite processing, your doctor will need the ID number from your CVS Caremark prescription ID card along with your date of birth and mailing address.

Please note: When a prescription is ordered using the CVS Caremark Mail Service Pharmacy, CVS Caremark will automatically dispense the generic equivalent if one is available and permissible by law, unless your physician has indicated that substitution is not allowed.

Using Mail Order if you have an Immediate Medication Need

If you will be using the CVS Caremark Mail Service Pharmacy, but need to begin taking a long-term medication immediately, have your doctor write two prescriptions:

- The first for up to a 30-day supply to be filled right away at any pharmacy that is participating in the CVS Caremark retail network – your doctor can call/fax this prescription to the pharmacy or provide it to you so you may take it to the pharmacy.
- The second for up to a 90-day supply to be filled through the CVS Caremark Mail Service Pharmacy using one of the methods described above.

Covered Expenses

The following are covered expenses under the Medical Plan unless listed as excluded below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes
- Glucose Monitors
- Over-the-Counter (OTC) Diabetic Supplies (lancets, lancet devices, alcohol wipes)
- Oral, Transdermal, Intravaginal and Injectable Contraceptives
- Contraceptive Emergency kits
- Drugs to Treat Impotency (Limits of 6 units per 30 days at retail, and 18 units per 90 days at mail for all dosage forms except Yohimbine)
- Inhaler Assisting Devices
- Peak flow meters
- Fertility Agents (100% after deductible, if applicable, up to \$2,500 per person per lifetime, then participant pays 50% of the cost of the drug)
- Influenza treatments at 1 treatment course per 180 days
- Zyban and Chantix (limit of 360 days of therapy per lifetime)
- Anti obesity Agents
- Products packaged as greater than a 30-day supply are covered through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy only

Excluded Expenses

The following are excluded from coverage under the Medical Plan unless specifically listed as a benefit under "Covered Expenses."

- Non-Federal Legend Drugs
- Non-systemic contraceptives, devices
- Smoking Deterrents (except as listed above)
- Nutritional Supplements
- Ostomy Supplies (covered as a medical expense under the Medical Plan)
- Glucowatch Products
- Mifeprex
- Therapeutic devices or appliances (including Diabetic Pumps and supplies, which are covered as a medical expense under the Medical Plan)
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums (covered as a medical expense under the Medical Plan)
- Biologicals, immunization agents or vaccines (except as noted below for certain routine vaccines)
- Blood or blood plasma products (covered as a medical expense under the Medical Plan)
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or from any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the participant

- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug

Medical Plan and Health Savings Account

If you have established a Health Savings Account and sufficient funds are available in your account, you may choose to pay any prescription drug annual deductible and coinsurance amounts with before-tax dollars by using your HSA debit card or checkbook.

Medical Plan and Health Care Spending Account

If you have enrolled in a Health Care Spending Account (HCSA) and are eligible to access HCSA funds, you may pay any prescription drug annual deductible and coinsurance amounts with before-tax dollars by filing for reimbursement from your HCSA or using your HCSA debit card.

SECTION 3 – COVERAGE DETAILS

CVS Caremark Primary/Preferred Drug List

Your cost for prescription purchases will vary depending on whether your physician prescribes a generic, preferred brand or non-preferred brand medication. By asking your physician to prescribe generic or preferred brand medications, you can help control rising health care costs.

Your prescription drug program incorporates a Primary/Preferred Drug List which lists the Medical Plan's preferred brand medications. The medications included on the list, which change from time to time, are commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings for the participant and the Medical Plan. For the most recent listing and to find out whether a medication is included in the Primary/Preferred Drug List, visit CVS Caremark online at www.Caremark.com or call CVS Caremark Customer Service at 888-797-8912. This listing is also available for viewing by employees on the Duke Energy Portal.

Refer to the prescription drug program summary of benefits on page 22 for more information about applicable coinsurance amounts for generic, preferred brand and non-preferred brand medications.

Preventive Medications

CVS Caremark maintains a list of certain medications prescribed to prevent the occurrence/re-occurrence of chronic illnesses. This list is referred to as the Preventive Therapy Drug List. Under your HSP option, preventive medications included on the Preventive Therapy Drug List are covered at 100% and are not subject to your HSP option's co-insurance or deductible when you use either a pharmacy that is participating in the CVS Caremark retail network or the CVS Caremark Mail Service Pharmacy to fill those prescriptions. This means that the Medical Plan will cover 100% of the cost and you will pay nothing, even if you have not met the applicable Medical Plan annual deductible.

Preventive medications are those items used to address risk factors for a disease that has not yet manifested itself, or to prevent the reoccurrence of a disease. Preventive medications do not include drugs for treatment of an existing illness or condition. A copy of the current Preventive Therapy Drug List is available on www.Caremark.com. CVS Caremark develops the Preventive Therapy Drug List in accordance with FDA and IRS guidelines regarding the types of medications that are considered "preventive" and therefore may be covered under your HSP option before the required deductible is satisfied. The Preventive Therapy Drug List is periodically updated to reflect new guidance issued and/or new drugs on the market.

Certain Contraceptive Medications Covered at 100%

The following contraceptive medications are covered at 100% (i.e., you do not pay anything when you purchase these items) when received from a pharmacy that is participating in the CVS Caremark retail network or the CVS Caremark Mail Service Pharmacy:

- Generic contraceptive medications; and

- Brand contraceptive medications where there is no generic available.

Note: If a generic version of a brand contraceptive medication becomes available, then only the generic contraceptive medication will be covered at 100%.

Certain Routine Vaccines Covered at 100%

The Medical Plan provides coverage for certain commonly administered vaccines at 100% when you present your CVS Caremark prescription ID card at a pharmacy that is participating in the CVS Caremark retail network. This is an alternative to getting certain immunizations from your doctor. Commonly administered vaccines available at a participating pharmacy through the Medical Plan include the following, where applicable:

- Hepatitis A (Adult)
- Hepatitis A (Child)
- Hepatitis B (Adult)
- Hepatitis B (Child)
- Human Papillomavirus (Gardasil)
- Influenza (Fluzone)
- Meningitis
- MMR (Measles, Mumps, Rubella)
- Pneumonia (Pneumovax)
- Polio (IPV)
- Shingles vaccine (Zostavax)
- TD (Tetanus, Diphtheria)
- Tdap (Tetanus, Diphtheria, Pertussis)

Please Note: Not all local pharmacies are staffed to provide immunizations and some may require a prescription to administer the vaccine based on requirements of particular states. Check with your local pharmacy for vaccine availability before you go.

CVS Caremark Specialty Medications and Specialty Guideline Management

Duke Energy participates in the CVS Caremark Specialty Guideline Management Program. This program supports safe, clinically appropriate and cost-effective use of specialty medications. Under your prescription drug program, some specialty medications may only be covered when ordered through CVS Caremark's specialty care pharmacy. CVS Caremark is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling.

Certain specialty medications such as treatments for Growth Hormone and related disorders, Hepatitis C, Multiple Sclerosis and Anemia will have additional management that ensures that the specialty medication continues to have appropriate lab testing and data reviewed to help ensure utilization of these specialty medications to be:

- clinically appropriate;
- safe; and

- effective for the patient throughout the duration of therapy.

For continued treatment with one of these specialty drugs, a periodic clinical review is required. CVS Caremark will obtain the necessary clinical information from your doctor's office and conduct the review.

The CVS Caremark Specialty Pharmacy provides not only your specialty medicines, but also personalized pharmacy care management services:

- Access to an on-call pharmacist 24 hours a day, seven days a week
- Coordination of care with you and your doctor
- Convenient delivery directly to you or to your doctor's office
- Medicine- and disease-specific education and counseling
- Online support through **www.Caremark.com/specialty**, including disease-specific information and interactive areas to submit questions to pharmacists and nurses

If a covered participant uses medications that are classified by CVS Caremark as specialty medications and wishes to use the prescription drug benefit, the participant should obtain these medications from CVS Caremark Specialty Pharmacy Services. Most of these same drugs also require prior authorization from CVS Caremark, as described below. These drugs are typically only available in up to a 30-day supply, even if taken on a long-term basis.

All specialty medications undergo external review of the program guidelines by clinical experts to ensure the program is unbiased and consistent with current standards of care and practice.

To answer any questions you may have about specialty medications or to find out what medications are considered to be specialty medications for purposes of the Medical Plan, you may contact CVS Caremark Specialty Pharmacy Services directly at 800-237-2767.

SECTION 4 – SPECIAL PROGRAMS

Step Therapy Program

In order to have coverage for prescription medications in certain drug classes, you must try a generic medication first to treat your condition. If you try (or have tried) a generic medication and it does not work for you, then you may receive coverage for a preferred brand medication that your doctor prescribes. If you try (or have tried) a preferred brand medication and it does not work for you, then you may receive coverage for a non-preferred brand medication that your doctor prescribes.

The amount you pay for your prescription will be lowest when you choose a generic medication. If no generic is available – or if it is not right for you – your Medical Plan provides coverage for preferred brand medications, which may also save you money.

However, if you choose to use a preferred brand medication without trying a generic first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the preferred brand medication. If you choose to use a non-preferred brand medication without trying a generic and preferred brand first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the non-preferred brand medication.

For information regarding the drug classes subject to the Step Therapy Program, call CVS Caremark at 888-797-8912.

Maximum Drug Limitation Program

The Medical Plan prescription drug benefits include quantity limits on certain medications, which are applied to address the problem of overuse of medications that can be unsafe for the patient. By following these guidelines, participants are assured of receiving the appropriate safe dosage recommended by the FDA. This means that:

- The Medical Plan will pay only for up to a specified quantity per 30- or 90-day periods.
- In addition, some medications have limitations on the day's supply of medication that may be dispensed to a patient at any one time.
- In certain drug classes, if the medical condition warrants a greater quantity than the established quantity limit, CVS Caremark will discuss the patient's needs with the patient's physician to determine if a greater quantity is medically necessary to treat the condition.

For information regarding the medications subject to the Maximum Drug Limitation Program, call CVS Caremark at 888-797-8912.

Prior Authorization

To ensure that drugs covered by the Medical Plan are used safely and appropriately, certain medications require that physicians obtain prior authorization from CVS Caremark *before* they are covered. Other classes may be added based upon safety, efficiency and FDA approved therapies. Call CVS Caremark at 888-797-8912 to determine if a medication requires prior authorization. Prior authorization does not guarantee coverage or payment under the Medical Plan.

Prior authorization also is required for a preferred brand medication to be covered prior to trying a generic medication, and for a non-preferred brand medication to be covered prior to trying a generic and preferred brand medication, as described above.

In order for medications which require prior authorization to be covered under the Medical Plan, your physician must obtain authorization from CVS Caremark at 800-294-5979 in advance of treatment with these medications.

Drug Utilization Reviews

Drug utilization reviews may help you guard against drug interaction problems that can occur, for example, when medications are prescribed by more than one physician. When your prescriptions are filled through the CVS Caremark Mail Service Pharmacy or at a pharmacy that is participating in the CVS Caremark retail network (using your CVS Caremark prescription ID card), they are reviewed for any potential drug interactions. This review is especially important if you or your covered family members take several medications or see more than one physician. If there is a question about your prescription, a registered pharmacist may contact your physician before dispensing the medication to discuss any alternatives and recommendations. You will be notified of any change in your prescribed medication. Your doctor makes the final decision on all of your prescription medications.

SECTION 5 – COORDINATION OF BENEFITS

Under the prescription drug program, CVS Caremark will not coordinate benefits for prescription drug expenses with other coverage you may have. That is, if you and/or your covered family members have prescription drug coverage under another plan, you may submit your prescription drug claims to whichever plan you choose. For example, if your spouse/domestic partner's medical plan does not cover prescription drugs or requires a higher deductible and coinsurance amount, you may want to use your CVS Caremark prescription ID card, instead of your spouse/domestic partner's plan, to obtain your prescriptions. Alternatively, if your spouse/domestic partner's medical plan requires co-pays to purchase prescription medications in lieu of deductibles and coinsurance, you may want to use your spouse/domestic partner's plan, instead of your CVS Caremark prescription ID card, to obtain your prescriptions.

SECTION 6 – CLAIMS PROCEDURES

How to File a Prescription Drug Program Claim

When you fill your prescription at a pharmacy that is participating in the CVS Caremark retail network and identify yourself as a CVS Caremark participant, you will not have to file a claim form. At the time your prescription is filled, you will have to pay the applicable deductible or coinsurance amount.

If you do not identify yourself to the pharmacist as a CVS Caremark participant, or if you do not use a pharmacy that is participating in the CVS Caremark retail network, you will need to file a claim for reimbursement of your prescription drug expenses through CVS Caremark. When you submit your claim, attach your original receipts and mail your claim to the address shown on the form. An original receipt should show the date of purchase, the name, cost, strength, quantity and days' supply of the medication, the prescription number and the NDC number. When you submit an original receipt, keep a copy for your records. Claim reimbursement is limited to CVS Caremark's discounted price less any required deductible and coinsurance.

CVS Caremark will consider claims for payment, provided your prescription claim is filed within 15 months from the date of service. Claims filed after 15 months from the date of service will not be considered for payment. For example, if you purchase a covered prescription medication on January 15, 2015, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2016 to receive reimbursement for your expenses.

If you are newly eligible, you have a 45-day grace period for prescription drug claims for purchases at full cost in situations where the prescription ID card was not used. The grace period allows participants to be reimbursed at 100%, less the applicable deductible and coinsurance, for paper claims submitted within 45 days from a participant's initial eligibility effective date with CVS Caremark. For example, a participant who's initial effective date with CVS Caremark is January 1, 2015 would have 45 days (until February 14, 2015) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

To obtain a claim form, call CVS Caremark Customer Service at 1-888-797-8912, or go online to **www.Caremark.com**.

Submit claim forms to:
CVS Caremark
P.O. Box 52196
Phoenix, AZ 85072-2196

Reviews & Appeals

The timing for review of your claim depends on the type of claim you submit, as described below. You may designate an authorized representative to assist you with the claims and appeals process described below.

Review Timing for Post-Service Claims

In the case of a post-service claim, CVS Caremark will notify you of the determination within 15 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CVS Caremark's control, it will notify you within 15 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

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

For these purposes, a post-service claim is any claim that is not a pre-service claim or an urgent care claim, each as defined below.

Review Timing for Pre-Service Claims (Claims Relating to Prior Authorization)

In the case of a pre-service claim, CVS Caremark will inform you of its decision (whether adverse or not) within a reasonable period of time appropriate to the medical condition, but not later than 15 days after it receives the claim. Under special circumstances, CVS Caremark may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which CVS Caremark expects to render a decision.

If additional information is needed because necessary information is missing from the request, the notice will specify what information is needed. You must provide the specified information to CVS Caremark within 45 days after receiving the notice. The determination period will be suspended on the date CVS Caremark sends a notice of missing information and the determination period will resume on the date you respond to the notice.

If you have not followed the proper procedures for filing your pre-service claim, you will be notified of the failure and the proper procedures to be followed in filing pre-service claims. This notice will be provided to you as soon as possible, but not later than 5 days, following the failure. This notification may be oral, unless you request written notification.

For these purposes, a pre-service claim means any claim for a benefit with respect to which the terms of the prescription drug program condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Review Timing for Urgent Care Claims

If your claim is an urgent care claim, CVS Caremark will notify you of its decision on your claim (whether adverse or not) as soon as possible, but no later than 72 hours after it receives the claim. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable, CVS Caremark will inform you as soon as possible, but no later than 24 hours after it receives the claim, of the specific information necessary to complete the claim. You will have a reasonable amount of time, taking into account the circumstances, but no less than 48 hours, to provide the specified information. CVS Caremark will notify you of its determination on your claim as soon as possible, and no later than 48 hours after the earlier of (1) CVS Caremark's receipt of the specified information and (2) the end of the period provided to you to provide the specified additional information.

If you have not followed the proper procedures for filing your urgent care claim, you will be notified of the failure and the proper procedures to be followed in filing urgent care claims. This notice will be provided to you as soon as possible, but not later than 24 hours, following the failure. This notification may be oral, unless you request written notification.

For these purposes, an urgent care claim is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Notice of Adverse Determination

In the event of an adverse benefit determination, in whole or in part, you will be notified of the adverse determination in writing.

An adverse benefit determination is a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Medical Plan benefit. An adverse benefit determination notification for any prescription drug program claim will contain:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the prescription drug program's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your rights to bring a civil action under section 502(a) of ERISA following any final internal adverse benefit determination on appeal;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;
- a statement that a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim is available free of charge upon request;
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims;

- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If the adverse benefit determination relates to an urgent care claim, the information described above may be provided to you orally within the required time frame, provided that a written or electronic notification is provided no later than 3 days after the oral notification.

When You Have a Complaint or an Appeal

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

- your name and participant ID number;
- your doctor's name and telephone number;
- the name of the medication; and
- any additional information from your pharmacy or medical provider that will assist CVS Caremark in completing its review of your appeal, such as documents, records, questions or comments.

Documents, records, written comments, and other information in support of your appeal should accompany your request. This information will be considered by CVS Caremark in reviewing your claim. You may request reasonable access to copies of all documents, records, and other information relevant to your claim. CVS Caremark will review your claim without granting any deference to the initial decision regarding your claim. Also, no reviewer may be a person that was involved in making the initial decision regarding your claim, or a subordinate to that person. If the claim was based, in whole or in part, on a medical judgment in reviewing the claim, CVS Caremark will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person (or a subordinate of a person) consulted by CVS Caremark in deciding the initial claim. Your appeal should be mailed to:

Caremark, Inc.
Department of Appeals, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

CVS Caremark can also be reached by fax at 866-689-3092. In the case of an appeal relating to an urgent care claim, you may request an expedited appeal orally by contacting CVS Caremark

at 888-797-8912 or in writing. All necessary information will be transmitted by telephone, fax or other available similarly expeditious manner.

To the extent required by applicable law:

- you will be allowed to review your claim file and to present evidence and testimony as part of the internal claims and appeals process;
- CVS Caremark will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the prescription drug program (or at the direction of the prescription drug program) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date; and
- if the denial of your appeal is based on a new or additional rationale, CVS Caremark will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Timing of Appeal Notification for Post-Service Claims

In the case of a post-service claim, CVS Caremark will notify you of its decision on your appeal within 30 days of its receipt of your request for review.

Timing of Appeal Notification for Pre-Service Claims (Claims Requiring Preauthorization)

In the case of a pre-service claim, CVS Caremark will provide notification of its determination on appeal within a reasonable amount of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

Timing of Appeal Notification for Urgent Care Claims

In the case of an urgent care claim, CVS Caremark will provide notification of its determination on appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request for review.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate the external appeals process;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and your right to bring an action under ERISA section 502(a) following any final internal adverse benefit determination;

- a statement that copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal are available upon request and free of charge;
- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Second Level Appeal Process for Post-Service Claims

If your post-service claim is denied on appeal, you have a right to bring a second appeal within 30 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in “When You Have a Complaint or Appeal” above. CVS Caremark will notify you of its decision on your appeal within 30 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in “Notice of Benefit Determination on Appeal” above, as well as the following statement: “You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

Second Level Appeal Process for Pre-Service Claims

If your pre-service claim is denied on appeal, you have a right to bring a second appeal within 15 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in “When You Have a Complaint or Appeal” above. CVS Caremark will notify you of its decision on your appeal within 15 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in “Notice of Benefit Determination on Appeal” above, as well as the following statement: “You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

Voluntary External Review Program

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

If you wish to file a request for external review, you must submit your request within 4 months of the date of your receipt of CVS Caremark’s final internal adverse determination on your

appeal. Contact CVS Caremark at the telephone number shown on your CVS Caremark prescription ID card for more information on how to file a request for external review of your appeal.

CVS Caremark will determine if your appeal is eligible for the voluntary external review program and will provide you with a written notice of its determination. If your request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the request complete, and, in order to pursue an external review, you must provide the required information within the 4-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

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

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

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

If your request for external review relates to an urgent care claim, CVS Caremark will determine if the appeal is eligible for the voluntary external review program and will provide you with written notice of its determination immediately. If the urgent care claim is eligible for external review, CVS Caremark will assign the urgent care claim to an IRO as described above. The IRO will review all of the information and documents relevant to the appeal, to the extent the information and documents are available and the IRO considers them appropriate. The IRO will provide notice to you and the Medical Plan of the final external review decision as soon as possible, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not provided in writing, the IRO will provide you and the Medical Plan with a written confirmation of its decision within 48 hours after the date of providing the notice.

Legal Action

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

Discretionary Authority

The authority to decide initial claims for prescription drug program benefits under the prescription drug program and denied claims for prescription drug benefits on review under the prescription drug program includes the full power and discretion to interpret prescription drug program provisions and to make factual determinations, with CVS Caremark's decisions, interpretations and factual determinations controlling, unless overturned through the voluntary external review program described above. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to CVS Caremark at the address listed above. Call CVS Caremark Customer Service for additional information regarding the appeals process.

This is a guide of covered expenses and expenses not covered under the prescription drug program. This guide contains selected highlights of Duke Energy's employee benefits plans. If any statement herein, or any other communication, conflicts with the applicable plan documents, the plan documents will govern. Duke Energy retains the right to amend, modify or terminate its benefits plans in any respect and at any time, and neither its benefits plans, nor your plan participation, will be considered a contract for future employment. For more information about applicable deductibles, coinsurance and plan limits, please call CVS Caremark Customer Service or visit www.Caremark.com. For more detailed information on the Medical Plan, refer to the Duke Energy Active Medical Plan General Information Booklet and UnitedHealthcare® Benefits Booklet sections of this Summary Plan Description.

UnitedHealthcare® is a registered mark of United Health Group, Inc.

SECTION 7 – PRESCRIPTION DRUG BENEFIT SUMMARY

	CVS Caremark Retail Pharmacy Network For short-term medications (up to a 30-day supply) you pay:	Maintenance Choice[®] CVS Caremark Mail Service Pharmacy or CVS Retail Pharmacy For long-term medications (up to a 90-day supply) you pay:
Preventive Medications Includes certain contraceptive medications and routine vaccines	\$0	\$0
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	20% of medication cost (after your deductible has been met)	20% of medication cost (after your deductible has been met)
Preferred Brand Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from the CVS Caremark Primary/Preferred Drug List.	20% of medication cost (after your deductible has been met)	20% of medication cost (after your deductible has been met)
Non-Preferred Brand Medications You will pay the most for medications not on the CVS Caremark Primary/Preferred Drug List.	20% of medication cost (after your deductible has been met)	20% of medication cost (after your deductible has been met)
Refill Limit	None	None
Annual In-Network Deductible The deductible is a combined medical and prescription drug deductible.	\$2,500 per year for individual coverage / \$5,000* per year for family coverage	
Out-of-Pocket Maximum** The out-of-pocket maximum is a combined medical and prescription drug out-of-pocket maximum.	\$5,000 per year for individual coverage / \$10,000*** per year for family coverage	

*The deductible is a true family deductible. The full \$5,000 amount must be reached before the Medical Plan pays any benefit for any covered member of the family (other than in-network benefits for certain preventive care services and preventive medications, including certain contraceptives and routine vaccines).

**Amounts you pay to satisfy the deductible and amounts you pay as co-insurance are applied toward your out-of-pocket maximum and are included for purposes of determining whether you have reached your out-of-pocket maximum.

***Not to exceed \$6,850 for any one individual

Maintenance Choice[®] is a registered mark of Caremark, LLC.



Active Medical Plan

Health Savings Plan 2 option

***Duke Energy Active Medical Plan
General Information***

IMPORTANT NOTICE

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

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

This General Information booklet, together with the Medical Plan booklets and summaries of benefits, is the Summary Plan Description (SPD) for the Medical Plan as of January 2016 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, prescription drug, wellness and disease management benefits.

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

Duke Energy myHR™ Service Center

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

Eligibility

Eligible Employees

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

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

- regular employee; or
- fixed-term employee.

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

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

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

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

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

Eligible Dependents

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

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

Spouse Eligibility

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

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

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

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

Domestic Partner Eligibility

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

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

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

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

Child Eligibility

Your child is:

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

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

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

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

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

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

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

Surviving Spouse, Domestic Partner and Child Eligibility

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

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

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

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

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

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

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

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

If you are covered under the Medical Plan and your spouse/domestic partner is an eligible retiree who is covered as your dependent, your spouse/domestic partner may elect retiree coverage under the Duke Energy Retiree Medical Plan at the time of your death if your spouse/domestic partner has not reached age 65 at the time of your death, or under the Connector Program if your spouse/domestic partner is age 65 or older at the time of your death.

Employee and Retiree Couples

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

Verification of Dependent Status

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

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

If a Dependent Becomes Ineligible

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

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

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage; and
- changes to your contribution amounts will be made as soon as administratively practicable after the date on which you notify the Duke Energy myHR Service Center that your dependent is no longer eligible.

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

- the dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage;
- no changes to your coverage level, if applicable, may be made until the next annual enrollment period or, if earlier, the date you experience another work/life event which allows you to change your Medical Plan election (this means that you must continue to pay for the dependent's coverage through the end of the year in which the dependent loses eligibility for coverage even though he or she is no longer covered, unless you experience another work/life event which allows you to change your Medical Plan election);
- the coverage provided while your dependent is ineligible will be considered as part of the individual's COBRA coverage period (this period begins on the first day of the month following the month in which eligibility is lost); and
- COBRA contributions (102% of the total cost) will be required to pay for the coverage received since the end of the month in which eligibility was lost if the individual elects continuation of coverage under COBRA.

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

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

Enrolling in the Medical Plan

When You Are First Eligible

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

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

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

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

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

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

You also may decline coverage altogether.

During Annual Enrollment

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

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

Other Opportunities to Enroll

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

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

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

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

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

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

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

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

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

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

If You Are Rehired

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

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

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

Cost of Coverage

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

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

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

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

Live Well Incentive Program

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

Employee Eligibility

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

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

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

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

Spouse/Domestic Partner Eligibility

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

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

***Live Well* Program Activities and Rewards**

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

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

Non-Tobacco User Discount

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

- be tobacco free (including smokeless tobacco and electronic cigarettes);
- have been tobacco-free (including smokeless tobacco and electronic cigarettes) during the 12 months preceding the effective date of your coverage; and
- remain tobacco free (including smokeless tobacco and electronic cigarettes) during the coverage period.

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

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

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

By completing the Attestation in the online enrollment tool or through the Duke Energy myHR Service Center, you are affirmatively representing your (and your spouse's/domestic partner's)

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

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

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

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

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

- If you are enrolling as a newly eligible employee (and/or a newly eligible spouse/domestic partner), you must:
 - indicate at enrollment that you (and/or your covered spouse/domestic partner) are a tobacco user, and
 - enroll in the QuitPower Tobacco Cessation Program (the “QuitPower Program”) within 31 days of the date you enroll in your benefits, and
 - properly complete and submit a written Alternate Procedure Certification within 31 days of the date you (and/or your spouse/domestic partner) enroll in your benefits certifying that you (and/or your spouse/domestic partner) have enrolled in the QuitPower Program and that you (and/or your spouse/domestic partner) will complete the QuitPower Program within seven months of enrolling in the QuitPower Program² – or –

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

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

The Alternate Procedure Certification is found on the Duke Energy Portal's *Employee Center – Annual Enrollment* page during annual benefits enrollment. If you are enrolling as a newly eligible employee, the Alternate Procedure Certification is found on the *Employee Center – New Employee Orientation* page. You may contact the Duke Energy myHR Service Center to discuss remitting the information required under the alternate procedure. You will not receive the non-tobacco user discount until your Alternate Procedure Certification has been approved, at which time the non-tobacco user discount will be applied on a prospective basis as soon as administratively practicable.

To enroll in the QuitPower Program, contact QuitPower at 1-877-784-8797. You (and/or your spouse/domestic partner) will not be required to pay for the cost of the QuitPower Program. Please note that the QuitPower Program takes up to six months to complete. You can begin the QuitPower Program as soon as you enroll. After your (and/or your spouse's/domestic partner's) initial year of claiming the discount in accordance with this procedure, in order to continue the non-tobacco user discount under the alternate procedure in any future year, a new Alternate Procedure Certification will be required.

If You Do Not Successfully Complete the Alternate Procedure

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

If You Misrepresent Information in the Alternate Procedure Certification

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

Termination of Coverage for Non-Payment

Your coverage will be terminated for non-payment if:

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

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

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

When Coverage and Contributions Begin

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

Mid-Year Changes

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

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

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

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

- Your legal marital status changes
 - you get married

- you get divorced or have your marriage annulled
- you get legally separated and lose coverage under your spouse's employer plan
- your spouse dies
- Your domestic partner status changes
 - your domestic partner becomes eligible for coverage
 - your domestic partner relationship ends
 - your domestic partner dies
- The number of your eligible children changes
 - you have, or adopt, a child
 - you become the legal guardian of a child
 - your child gains or loses eligibility for coverage under the Medical Plan (for example, your dependent child reaches age 26)
 - a Qualified Medical Child Support Order (QMCSO) is received³
 - your child dies
- Your dependent's benefits coverage changes because:
 - he or she gains or loses coverage due to a change in eligibility as a result of a change in employment status or work schedule
 - his or her period of coverage and annual enrollment window is different from yours
- Your or your dependent's COBRA coverage from another employer expires
- You enroll in a qualified health plan through a federal or state Marketplace during the Marketplace's annual enrollment period or during a special enrollment period available in the Marketplace
- You or your dependent becomes entitled to or loses Medicare or Medicaid⁴
- 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 Your Dependent Is No Longer Eligible

If a covered dependent ceases to be eligible for benefits, your dependent's coverage ends at midnight on the last day of the month in which the dependent loses eligibility for coverage. If

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

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

you notify the Duke Energy myHR Service Center within 31 calendar days of the loss of eligibility, changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice. See *If a Dependent Becomes Ineligible* for information about the consequences of failing to notify the Duke Energy myHR Service Center within 31 calendar days of a loss of eligibility.

When You Enroll a Dependent Mid-Year

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

When Mid-Year Coverage and Contribution Changes Are Effective

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

- **Start or Increase Coverage.** If you elect to start or increase your coverage due to a work/life event, your coverage changes on the day the work/life event occurred. In order for the change to take effect on the day the work/life event occurred, you must notify the Duke Energy myHR Service Center within 31 calendar days of the work/life event. Changes to your contribution amounts are effective as soon as administratively practicable after you submit your election changes.
- **Elective Decrease or Termination of Coverage.** If you elect to decrease or terminate coverage due to a work/life event, your coverage changes on the first day of the month after you submit your election changes. You must notify the Duke Energy myHR Service Center within 31 calendar days of the work/life event in order for the change to become effective on the first day of the month after you submit your election changes. Changes to your contribution amounts are effective as soon as administratively practicable after you submit your election changes.
- **Decrease or Termination of Coverage Due to Loss of Eligibility.** Coverage for individuals who are no longer eligible ends at midnight on the last day of the month in which the individual loses eligibility for coverage. Changes to your contribution amounts generally are effective as soon as administratively practicable after you submit your election changes provided that you notify the Duke Energy myHR Service Center within 31 days of the loss of eligibility. See *If a Dependent Becomes Ineligible* above for the consequences of failing to notify the Duke Energy myHR Service Center of a covered individual's ineligibility within 31 calendar days of the loss of eligibility. Note that in the

event of your death, coverage for you and your dependents ends on the date of your death. See *Surviving Spouse, Domestic Partner and Child Eligibility* above for information about coverage available to your spouse/domestic partner and/or child if you die while they are covered under the Medical Plan.

Situations Impacting Your Eligibility for Coverage

If You Are on an Authorized Leave of Absence

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

If You Become Disabled

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

When You Reach Age 65

If you continue to work past age 65, Medical Plan coverage for you and your covered dependents will continue as long as you remain an eligible employee, your covered dependents remain eligible dependents and you pay any required contributions. If you continue to work past age 65, your Medical Plan coverage will be primary to Medicare for you and any covered dependents over age 65.

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 a Medical Plan option that coordinates with Medicare. For these purposes, you are considered to be “not actively at work” if you are not actively working as an employee or you have been receiving long-term disability benefits for six months or longer. Contact the Duke Energy myHR Service Center for additional information regarding the options available to you when you become entitled to Medicare.

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

If you are “not actively at work” because you have been receiving long-term disability benefits for six months or longer and you and/or a covered dependent enroll in a Medicare prescription

drug plan for a calendar year, you and/or your covered dependent will not be eligible for coverage under the Medical Plan for that calendar year. Therefore, Medical Plan coverage ends for a calendar year for individuals who enroll in a Medicare prescription drug plan mid-year. Such individuals may be able to enroll for Medical Plan coverage at the next annual enrollment if Medicare prescription drug coverage is dropped for the following calendar year.

Termination of Coverage

When Coverage Ends

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

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

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

If You Become Divorced or Your Domestic Partner Relationship Ends

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

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

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

If You Leave the Company

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

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

If You Retire

If you are an eligible retiree, you may elect retiree coverage under the Duke Energy Retiree Medical Plan if you have not reached age 65 when you retire, or under the Connector Program if you are age 65 or older when you retire. Refer to the applicable Summary Plan Descriptions for additional information about retiree coverage under those plans.

COBRA Continuation Coverage

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

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

Continued Coverage for You

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

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

Continued Coverage for Your Dependents

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

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

Newborn and Adopted Children

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

In Case of Disability

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

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

If You Become Covered by Medicare

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

For example, suppose you are actively employed on January 1, 2016, when you reach age 65 and become covered under Medicare. If you terminate your employment (a qualifying event) 12 months later on January 1, 2017, 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, 2019; or
- 18 months following your termination of employment – July 1, 2018

In this case, your eligible dependents would be eligible for continued coverage until January 1, 2019 if COBRA continuation coverage is elected.

Multiple Qualifying Events

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

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

Procedures to Obtain Continued Coverage

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

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

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

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

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

Election Period

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

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

Type of Coverage

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

Cost

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

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

Termination of Continued Coverage

COBRA coverage automatically ends if any of the following occurs:

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

Conversion Privilege

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

Qualified Medical Child Support Orders (QMCSOs)

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

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

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

If the child's covered expenses are paid by a custodial parent or legal guardian who is not a participant in the Medical Plan, reimbursement of these expenses will be made directly to the custodial parent or legal guardian if required by the order. Custodial parents and legal guardians

also may sign claim forms and assign benefits to providers. The Claims Administrator will send notification of payment of providers to the custodial parent.

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

Your Role

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

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

You must notify the applicable Claims Administrator if a provider:

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

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

Other Important Information

Plan Sponsor

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

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

Identification Numbers

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

Funding

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

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

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

Plan Administrator

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

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

Benefits Committee
Duke Energy Corporation
P.O. Box 1321, DEC38D
Charlotte, NC 28201
704-382-4703

Claims Committee
Duke Energy Corporation
P.O. Box 1321, DEC38D
Charlotte, NC 28201
704-382-4703

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

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

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

Investment Committee

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

The Investment Committee may be contacted through the following address:

Investment Committee
Director, Long Term Investments
Duke Energy Corporation
P.O. Box 1321, DEC40A
Charlotte, NC 28201

Plan Year

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

Service of Legal Process

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

Corporate Secretary
Duke Energy Corporation
550 South Tryon Street
Charlotte, North Carolina 28202

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

Affiliated Employers of Duke Energy That Have Adopted the Medical Plan

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

Claim Determination Procedures

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

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

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

Claims for Medical Plan Benefits

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

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

Eligibility or Enrollment Claims

Authority to decide an Eligibility or Enrollment Claim is assigned for initial claims to Duke Energy Human Resources, which is the Initial Claim Administrator. Duke Energy Human Resources has delegated its authority to Aon Hewitt Claims and Appeals Management. For denied Eligibility or Enrollment 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 Duke Energy myHR Service Center.

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

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

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

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

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

Adverse Determination

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

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

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a description of any additional information or material necessary to perfect the claim and an explanation of why such information or material is needed;

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

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

Appeal of Adverse Determination

If you disagree with an adverse eligibility or enrollment determination, you (or your authorized representative) can request a review of the initial determination by submitting a written request to the Claims Committee within 180 calendar days after receipt of the adverse determination. If your appeal is not filed within this period, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

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

Claims Committee
Duke Energy Corporation
P.O. Box 1321, DEC38D
Charlotte, NC 28201

You may request to examine and receive copies of all documents, records and other information relevant to the claim. The Claims Committee will review the appeal without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person that was involved in making the initial decision regarding the claim, or a subordinate to that person. In addition, if the claim was based in whole or in part on a medical judgment, the Claims Committee

will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This person will not be a person (or a subordinate of a person) consulted by Aon Hewitt Claims and Appeals Management in deciding the initial claim. When reviewing an adverse determination that has been appealed, any new information that you provide that was not available or utilized when the initial determination was made will be considered.

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

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

- the specific reason or reasons for the adverse determination;
- specific references to the pertinent Medical Plan provisions on which the adverse determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- a statement about your right to bring a civil action under Section 502(a) of ERISA;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion is available free of charge upon request;
- if denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limitation, a statement that the Plan Administrator or its designee will, upon request, provide you, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the Medical Plan to your medical circumstances;
- the following statement: ‘You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency’; and
- only to the extent required under applicable federal regulations:
 - information sufficient to identify the claim involved;
 - notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;

- a description of the Medical Plan's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

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

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

Voluntary External Review Program

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

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

The Claims Committee will determine if your appeal is eligible for the voluntary external review program and will provide you with a written notice of its determination. If your request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the request complete, and, in order to pursue an external review, you must provide the required information within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later. If you fail to provide the required information by the applicable deadline, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it.

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

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

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

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

Legal Action

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

Discretionary Authority

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

Right to Change or Terminate the Medical Plan

Duke Energy Corporation reserves the right to amend or terminate the Medical Plan in any respect and at any time. For example, the Medical Plan may be discontinued in part or in its entirety, or what the Medical Plan or Medical Plan option covers or what benefits it provides may be changed. Cost sharing between the Company and covered individuals also is subject to

change, which may include initiating or increasing contributions required of employees, retirees, other former employees and their dependents.

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

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

Statement of Rights

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

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Medical Plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Medical Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Medical Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- receive a summary of the Medical Plan's annual financial report. The Plan Administrator is required by law to furnish each participant in the Medical Plan with a copy of this summary financial report.
- obtain a copy of the Medical Plan's procedures for determining a Qualified Medical Child Support Order (QMCSO).

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse⁵ or dependents if there is a loss of coverage under the Medical Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this General Information

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

Booklet and the other documents governing the Medical Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

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

Assistance with Your Questions

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

Keep Us Informed

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

A Final Note

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

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

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Benefit Booklet

Duke Energy Active Medical Plan Health Savings Plan 2 Option

Effective: January 1, 2016
Group Number: 729784



DUKE ENERGY ACTIVE MEDICAL HEALTH SAVINGS PLAN 2 OPTION

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SECTION 1 - WELCOME

Quick Reference Box

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

Duke Energy is pleased to provide you with this Benefit Booklet, which describes the health Benefits available to you and your covered family members under the Duke Energy Active Medical Plan's Health Savings Plan 2 Option. It includes summaries of:

- Services that are covered, called Covered Health Services;
- Services that are not covered, called Exclusions;
- How Benefits are paid; and
- Your rights and responsibilities under the Plan.

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

Please read this Benefit Booklet thoroughly to learn how the Duke Energy Active Medical Plan's Health Savings Plan 2 Option works. If you have questions call the number on the back of your ID card.

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How To Use This Benefit Booklet

- Read the entire Benefit Booklet (including the benefit booklet describing the prescription drug benefit), as well as the General Information Booklet and share them with your family. Together, the General Information Booklet and the Benefit Booklets comprise the Summary Plan Description (SPD) for the Plan's Health Savings Plan 2 Option. Keep these documents in a safe place for future reference.
- Many of the sections of this Benefit Booklet are related to other sections. You may not have all the information you need by reading just one section.
- You can find or request printed copies of your SPD at <http://resources.hewitt.com/duke-energy> or by contacting the Duke Energy myHR Service Center at (888) 465-1300.
- Capitalized words in the Benefit Booklet have special meanings and are defined in Section 12, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 12, *Glossary*.
- Duke Energy and its affiliated companies which are participating in the Plan are also referred to as the Company.

SECTION 2 - HOW THE PLAN WORKS

What this section includes:

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

Accessing Benefits

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

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

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

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

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

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

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their

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charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

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

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

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

Health Services from Non-Network Providers Paid as Network Benefits

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

Looking for a Network Provider?

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

Network Providers

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

Network providers are independent practitioners and are not employees of Duke Energy or UnitedHealthcare.

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at www.myuhc.com or by calling the number on your ID card to request a copy.

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

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

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

Designated Facilities and Other Providers

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

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

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

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Limitations on Selection of Providers

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

Eligible Expenses

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

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

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

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

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

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

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
 - If rates have not been negotiated, then one of the following amounts:

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- For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
- For Mental Health Services and Substance Use Disorder Services the Eligible Expense are reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
- When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
- When a rate is not published by *CMS* for the service, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

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

Don't Forget Your ID Card

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

Annual Deductible

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

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

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

If more than one person in a family is covered under the Plan's Health Savings Plan 2 Option, the individual coverage Deductible stated in Section 4, *Plan Highlights* does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits (other than Benefits for Network preventive care services and certain preventive medications and vaccines) until the family Deductible is satisfied.

Coinsurance

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

Coinsurance - Example

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

Out-of-Pocket Maximum

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

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

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

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

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

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

SECTION 3 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services for which you need to contact Personal Health Support.

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

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

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

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

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss

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and share important health care information related to the participant's specific chronic or complex condition.

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

Requirements for Notifying Personal Health Support

Network providers are generally responsible for notifying Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying Personal Health Support.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying Personal Health Support as shown in Section 5, *Additional Coverage Details* before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if Personal Health Support is not notified, as shown in Section 5, *Additional Coverage Details*.

The services that require Personal Health Support notification are:

- Ambulance - non-emergent air;
- Autism treatment;
- Clinical Trials;
- Congenital heart disease surgery;
- Durable Medical Equipment for items that will cost more than \$1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
- Genetic testing;
- Home health care;
- Hospice care – inpatient;
- Hospital Inpatient Stay - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery;
- Lab, X-Ray and Diagnostics - Outpatient - sleep studies;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management);
- Neurobiological Disorders - Autism Spectrum Disorder Services -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility);
- Private Duty Nursing – outpatient;

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- Prosthetic devices;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Abuse Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Surgery - sleep apnea surgeries;
- Temporomandibular joint services;
- Therapeutics - all outpatient therapeutics;
- Transplants.

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

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

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

Special Note Regarding Medicare

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

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

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SECTION 4 - PLAN HIGHLIGHTS

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

Plan Features	Network	Non-Network
Annual Deductible¹		
■ Individual	\$1,500	\$3,000
■ Family (cumulative Annual Deductible ²)	\$3,000	\$6,000
Annual Out-of-Pocket Maximum¹		
■ Individual (enrolled in single coverage)	\$3,500	\$7,000
■ Individual (enrolled in family coverage)	\$6,850	\$14,000
■ Family (not to exceed the applicable Individual amount per Covered Person)	\$7,000	\$14,000
Lifetime Maximum Benefit³	Unlimited	
There is no dollar limit on the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.		

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

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

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

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

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

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
<p>Acupuncture Services</p> <p>Acupuncture services will be reviewed after 20 visits for medical necessity</p>	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
<p>Ambulance Services</p> <ul style="list-style-type: none"> ■ Emergency Ambulance ■ Non-Emergency Ambulance 	<p>80% after you meet the Annual Deductible</p> <p>80% after you meet the Annual Deductible</p>	<p>80% after you meet the Annual Deductible</p> <p>60% after you meet the Annual Deductible</p>
<p>Cancer Resource Services (CRS)²</p> <ul style="list-style-type: none"> ■ Hospital Inpatient Stay <p>See <i>Cancer Resource Services (CRS)</i> in Section 5, <i>Additional Coverage Details</i>.</p>	80% after you meet the Annual Deductible	Not Covered
<p>Clinical Trials</p> <p>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a Network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)</p>	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each applicable Covered Health Service category in this section.	

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Congenital Heart Disease (CHD) Surgery Services²	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services -Treatment of a Medical Condition	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Treatment Covered under Plan	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
<p>Diabetes Services</p> <p>Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care</p> <p>Diabetes Self-Management Items</p> <ul style="list-style-type: none"> ■ Diabetes equipment (insulin pumps and pump supplies only). <p>See <i>Durable Medical Equipment</i> in Section 5, <i>Additional Coverage Details</i>, for limits</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each applicable Covered Health Service category in this section.</p> <p>Benefits for diabetes equipment will be the same as those stated under <i>Durable Medical Equipment</i> in this section.</p>	
<p>Durable Medical Equipment (DME)</p> <p>See <i>Durable Medical Equipment</i> in Section 5, <i>Additional Coverage Details</i>, for limits</p>	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

DUKE ENERGY ACTIVE MEDICAL HEALTH SAVINGS PLAN 2 OPTION

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Emergency Health Services – Outpatient	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Foot Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Home Health Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Kidney Resource Services (KRS)² (These Benefits are for Covered Health Services provided through KRS only)	80% after you meet the Annual Deductible	Not Covered
Lab, X-Ray and Diagnostics - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

DUKE ENERGY ACTIVE MEDICAL HEALTH SAVINGS PLAN 2 OPTION

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Mental Health Services <ul style="list-style-type: none"> ■ Inpatient. ■ Outpatient. 	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services <ul style="list-style-type: none"> ■ Inpatient. ■ Outpatient. 	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Nutritional Counseling Up to 6 visits per condition per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Obesity Surgery² (The Plan pays Benefits only for Covered Health Services provided through BRS)	80% after you meet the Annual Deductible	Not Covered
Orthotic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

DUKE ENERGY ACTIVE MEDICAL HEALTH SAVINGS PLAN 2 OPTION

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

DUKE ENERGY ACTIVE MEDICAL HEALTH SAVINGS PLAN 2 OPTION

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment <ul style="list-style-type: none"> ■ Cardiac & Pulmonary Rehabilitation Services ■ All other services See Rehabilitation Services-Outpatient Therapy in Section 5, <i>Additional Coverage Details</i> , for limits.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 150 days per Covered Person per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Spine and Joint Solution (SJS) Program (Covered Person is 18 years of age or older and enrolls and participates in SJS)	Depending upon where the Covered Health Service is provided, Benefits for select elective, inpatient surgeries will be the same as those stated under each applicable Covered Health Service category in this section	

DUKE ENERGY ACTIVE MEDICAL HEALTH SAVINGS PLAN 2 OPTION

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan	
	Network	Non-Network
Substance Use Disorder Services <ul style="list-style-type: none"> ■ Inpatient ■ Outpatient 	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Surgery - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services Any combination of Network and Non-Network Benefits for oral appliances and associated expenses are limited to a \$1,500 maximum per Covered Person per lifetime.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Transplantation Services Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each applicable Covered Health Service category in this section.	
Travel and Lodging (If services rendered by a Designated Facility)	For patient and companion(s) of patient undergoing transplant, obesity surgery, Spine and Joint Solution (SJS) program surgery services, cancer treatment or Congenital Heart Disease treatment	

DUKE ENERGY ACTIVE MEDICAL HEALTH SAVINGS PLAN 2 OPTION

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

¹You must notify Personal Health Support, as described in Section 3, *Personal Health Support* to receive full Benefits for certain Covered Health Services. See Section 5, *Additional Coverage Details* for further information.

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

SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Covered Health Services that require you to notify the Claims Administrator or Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call the Claims Administrator or Personal Health Support.

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

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

Acupuncture Services

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

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

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

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

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

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

Did you know...

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

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Ambulance Services

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

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

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

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

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services, please remember that you should notify the Claims Administrator or Personal Health Support as soon as possible prior to the transport.

Cancer Resource Services (CRS)

The Plan encourages Benefits for oncology services to be provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 12, *Glossary*.

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

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

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

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.

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- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

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

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

Clinical Trials

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

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

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

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

Routine patient care costs for qualifying Clinical Trials include:

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

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Routine costs for Clinical Trials do not include:

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

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*).
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
 - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.

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- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember that you should notify the Claims Administrator or Personal Health Support as soon as the possibility of participation in a Clinical Trial arises.

Congenital Heart Disease (CHD) Surgery Services

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

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

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

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

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

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

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

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

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

Dental Services - Accident Only

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

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

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

Dental services for final treatment to repair the damage caused by accidental Injury must be started within 3 months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

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

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.

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- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Dental Services - Treatment of a Medical Condition

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

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

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

Dental Treatment Covered under Plan

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

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

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

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

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When any of the conditions listed above require surgical correction, Benefits for surgery will be subject to a Covered Health Service review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth.

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

Diabetes Services

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

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	<p>Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.</p> <p>Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.</p>
Diabetic Self-Management Items	<ul style="list-style-type: none"> ■ Insulin pumps and pump supplies for the management and treatment of diabetes. <p>Insulin pumps are subject to all the conditions of coverage stated under <i>Durable Medical Equipment</i> in this section.</p>

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

Please remember for Non-Network Benefits, you should notify Personal Health Support before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the purchase, rental, repair or replacement of DME will cost more than \$1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies.

Durable Medical Equipment (DME)

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

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

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

Examples of DME include but are not limited to:

- Equipment to administer oxygen;
- Equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- Delivery pumps for tube feedings;
- Breast pumps (only as provided under the Health Resources and Services Administration (HRSA) requirement);
- Negative pressure wound therapy pumps (wound vacuums);
- Burn garments;
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See Hospital – Inpatient Stay, Rehabilitation Services – Outpatient Therapy and Surgery – Outpatient in this section;
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage;
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

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

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

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

Braces that straighten or change the shape of a body part, including but not limited to cranial bands for correction of positional plagiocephaly, and shoes/inserts made from a mold of a Covered Person's foot are considered orthotic devices and are Covered Health Services.

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

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

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

Please remember for Non-Network Benefits, you should notify the Claims Administrator or Personal Health Support if the retail purchase cost or cumulative rental cost of a single item will exceed \$1,000. You must purchase or rent the DME from the vendor the Claims Administrator or Personal Health Support identifies or purchase it directly from the prescribing Network Physician.

Emergency Health Services - Outpatient

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

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after

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the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 2, *How the Plan Works*.

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

Please remember for Non-Network Benefits, you should notify the Claims Administrator within 48 hours of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency.

Foot Care

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

Home Health Care

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

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 12, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 12, *Glossary* for the definition of Skilled Care.

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

Please remember for Non-Network Benefits, you should notify the Claims Administrator or Personal Health Support five business days before receiving services or as soon as reasonably possible.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while

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the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support five business days before receiving services. If the Claims Administrator or Personal Health Support is not notified of Hospice care provided on an inpatient basis, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

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

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

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Please remember for Non-Network Benefits, you must notify Personal Health Support or the Claims Administrator as follows:

- For a scheduled admission: five business days before admission or as soon as reasonably possible.
- For non-scheduled admissions (including Emergency admissions): as soon as is reasonably possible.

If the Claims Administrator is not notified, Benefits will be reduced to 50% of Eligible Expenses.

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Kidney Resource Services (KRS)

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

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

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

You or a covered Dependent may:

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

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

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

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

Lab, X-Ray and Diagnostics - Outpatient

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

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

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

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

For Non-Network Benefits for sleep studies you must notify the Claim Administrator or Personal Health Support five business days before scheduled services are received.

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

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

Benefits under this section include:

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

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

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment;
- Treatment planning;
- Treatment and/or procedures;
- Referral services;
- Medication management;
- Individual, family, therapeutic group and provider-based case management services;
- Crisis intervention;
- Partial Hospitalization/Day Treatment;

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- Services at a Residential Treatment Facility;
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services Benefit. Depending on the type of programs or services available, the programs or services may be offered to you at no cost or as an exchange of Benefits. When offered as an exchange of Benefits for use of these programs or services, this exchange is based on the assignment of the program or service to either inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use and any associated Coinsurance and Deductible. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Non-Network Benefits, you must notify the Mental Health/Substance Use Disorder Administrator to receive these Benefits in advance of any treatment. Please call the number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder Services (otherwise known as neurodevelopmental disorders) that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

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

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment;
- Treatment planning;

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- Treatment and/or procedures;
- Referral services;
- Medication management;
- Individual, family, therapeutic group and provider-based case management services;
- Crisis intervention;
- Partial Hospitalization/Day Treatment;
- Services at a Residential Treatment Facility;
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please call the number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Nutritional Counseling

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

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

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

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

Benefits are limited to six individual sessions per calendar year for each medical condition.

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Obesity Surgery

(The Plan pays Benefits only for Covered Health Services provided through BRS)

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician if any of the following are true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea, hypertension, cardiopulmonary condition or diabetes) directly related to, or exacerbated by obesity.

In addition to meeting the above criteria the following must also be true:

- you have any life threatening or serious medical condition that is weight induced;
- dietary attempts at weight control have been ineffective through completion of a structured diet program, such as WeightWatchers or Jenny Craig (on-line program not accepted) for six consecutive months;
- a psychological examination of the Covered Person's readiness and fitness for surgery and the necessary postoperative lifestyle changes has been completed;
- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years;
- you have completed a 6-month Physician supervised weight loss program; and
- you have completed a pre-surgical psychological evaluation.

Coverage of surgical treatment of morbid obesity is limited to adults who are 18 years old or older.

You will have access to a certain Network of Designated Facilities and Physicians participating in the Bariatric Resource Services (BRS) program, as defined in Section 12, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling the toll-free number on the back of your ID card.

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

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 12, *Glossary* and are not Experimental or Investigational or Unproven Services.

Please remember Non-Network Benefits for obesity surgery are not available.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

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

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-Ray and Diagnostics - Outpatient*.

Please remember for Non-Network Benefits, you should notify the Claims Administrator for Genetic Testing, including BRCA Genetic Testing.

Please Note

Your Physician does not have a copy of your Benefit Booklet, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a doctor or other health care provider obtain certification for prescribing a length of stay of up to 48 hours (or 96

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hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain certification.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If the Claims Administrator or Personal Health Support is not notified, Benefits for the extended stay will be reduced to 50% of Eligible Expenses

Healthy moms and babies

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 6, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Examples of preventive care services include routine physical examinations, well-baby and well-child care, immunizations, screening mammograms and prostate screenings. Preventive care Benefits for women defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting or purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 4, *Plan Highlights*, under *Covered Health Services*.

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If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

Preventive care Benefits for women defined under the Health Resources and Services Administration (HRSA) requirement also include the following:

- Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes;
- Human papillomavirus testing in women with normal cytology results beginning at age 30 and no more frequently than once every three years;
- Annual counseling for sexually transmitted infections;
- Annual counseling and screening for human immune-deficiency virus;
- Comprehensive lactation support and counseling in conjunction with each birth, by a trained provider during pregnancy and/or in the postpartum period;
- All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity, as prescribed by a doctor; and
- Annual screening and counseling for interpersonal and domestic violence.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), as defined in Section 12, *Glossary*.

Please remember that you should notify Personal Health Support for Private Duty Nursing – Outpatient visits.
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Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every five calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are more than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Please remember that you should notify Personal Health Support for Prosthetic Devices.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

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Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 12, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Please remember that for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support five business days before undergoing a Reconstructive Procedure. If the Claims Administrator or Personal Health Support is not notified, Benefits for the extended stay will be reduced to 50% of Eligible Expenses. When you provide notification, the Claims Administrator or Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy and Manipulative/Chiropractic Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy;
- Occupational therapy;
- Manipulative/Chiropractic Treatment;
- Speech therapy;
- Post-cochlear implant aural therapy;
- Pulmonary rehabilitation;
- Cardiac rehabilitation; and

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- Limited treatment of Autism Spectrum Disorders.

Please remember that you must notify Personal Health Support for treatment of autism. If Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

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Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. Rehabilitation services will be reviewed after 40 visits for medical necessity.

Also, other than as described under Habilitative Services above, Physical therapy, Occupational therapy and Post-cochlear implant aural therapy will be reviewed after 40 visits for medical necessity.

Manipulative/Chiropractic Treatment will be reviewed after 20 visits for medical necessity.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

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

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

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- Supplies and non-Physician services received during the Inpatient Stay.

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- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

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

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 150 days per Covered Person per calendar year.

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Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support as follows:

- For a scheduled admission: five business days before admission.
- For non-scheduled admissions as soon as is reasonably possible.

If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Spine and Joint Solution (SJS) Program

The Spine and Joint Solution is a surgical program that provides access to quality, designated surgical facilities and case management support for individuals who meet the criteria for select elective, inpatient surgeries. The Covered Person must be 18 years of age or older and enrolled and participating in the SJS Program. When you contact the specialized nurse team to enroll and participate in the SJS program, the Plan pays Benefits for the SJS surgeries.

Surgeries considered in scope for the SJS program:

- Spine fusion surgery
- Spine disk surgery
- Total hip replacement
- Total knee replacement

The SJS program enrollment and participation is mandatory to receive benefits coverage.

Covered Persons planning any SJS surgeries must contact SJS to enroll in the program in order for the surgery to be a considered as a Covered Health Service. Contact SJS:

- As soon as the possibility of the surgical procedure arises;
- Before the time a pre-surgical evaluation is completed;
- Before the procedure is performed.

In order for the surgery to be considered as a Covered Health Service, you are required to use a Designated Facility if you live within 90 miles of a facility. Facilities will be identified when enrolling in the program.

Travel and Lodging Assistance is available as part of the Spine and Joint Solution (SJS) program. See *Travel and Lodging* for details.

If you are considering any of the above surgeries you must contact SJS prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

To enroll in the Spine and Joint Solution (SJS) program: You or your doctor may call the toll-free number on the back of your ID Card. The Plan will only pay Benefits under the SJS program if you enroll with the SJS Nurse team and participate in the SJS program.

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Resources: Contact Nurseline with any questions or concerns you might have in regard to the SJS program, call toll-free at **1-877-370-4001** or directly email optumspineandjoint@optum.com.

Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment;
- Treatment planning;
- Treatment and/or procedures;
- Referral services;
- Medication management;
- Individual, family, therapeutic group and provider-based case management services;
- Crisis intervention;
- Partial Hospitalization/Day Treatment;
- Services at a Residential Treatment Facility;
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services Benefits. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

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Please remember for Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

For Non-Network Benefits for sleep apnea surgeries you must notify the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within 48 hours or as soon as is reasonably possible. If you fail to notify the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and

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- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration (FDA)*-approved TMJ implants only when all other treatment has failed.

Any combination of Network Benefits and Non-Network Benefits for oral appliances and associated expenses is limited to a \$1,500 maximum per Covered Person per lifetime.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Please remember for Non-Network Benefits, you must notify Personal Health Support five business days before temporomandibular joint services are performed during an Inpatient Hospital Stay in a Hospital. If Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

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

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support for all outpatient therapeutics five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as reasonably possible.

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Transplantation Services

The Plan pays Benefits for organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Designated Facility, Network facility that is not a Designated Facility or a non-Network facility.

Benefits are also available for cornea transplants. You are not required to notify the Claims Administrator or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Facility.

Please remember for Non-Network Benefits, you must notify the Claims Administrator or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If the Claims Administrator or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Travel and Lodging

The Claims Administrator will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD) services;
- Obesity surgery services;
- Transplantation services;
- Cancer-related treatments;
- Spine and Joint Solution (SJS) program surgery services.

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For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the obesity surgery service, the CHD service, the transplant for the purposes of an evaluation or the SJS surgery services, the procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to \$50 per day for the patient or up to \$100 per day for the patient plus one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to \$100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility (for BRS, CRS, transplantation and SJS) or the CHD facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- Airfare at coach rate.
- Taxi or ground transportation.
- Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A combined overall maximum Benefit of \$10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all cancer treatments, transplant procedures, CHD treatments, obesity surgery services and SJS services during the entire period that person is covered under this Plan.

Support in the event of serious illness

If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 12, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

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Virtual Visits

The Plan provides Benefits for virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Vision Examinations

The Plan pays Benefits for:

- Vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment).
- One routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every calendar year.
- Non routine vision exam and refraction eye exam (Vision Exam - medical/surgical eye care is typically problem-oriented, involving the use of medication and/or surgical procedures to diagnose and treat eye problems, such as glaucoma, pink eye and cataracts. Refractive eye exam – external and internal exam, neurological integrity, pupillary reflexes, versions, biomicroscopy, tonometry, visual acuity, subjective, refraction, accomodative function, binocular function).

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from treatment of malignancy or permanent loss of hair from an accidental injury.

Any combination of Network Benefits and Non-Network Benefits is limited to a \$500 maximum per Covered Person per lifetime.

SECTION 6 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:

Health and well-being resources available to you, including:

- Condition Management Services; and
- Telephonic Wellness Coaching.

Duke Energy believes in giving you the tools you need to be an educated health care consumer. To that end, Duke Energy has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Duke Energy are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

NurseLineSM

NurseLineSM is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Duke Energy has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drug products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLineSM gives you another convenient way to access health information. By calling the same number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

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NurseLineSM is available to you at no cost. To use this convenient service, simply call the number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLineSM.

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLineSM any time, 24 hours a day, seven days a week. You can count on NurseLineSM to help answer your health questions.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium[®] Program

To help people make more informed choices about their health care, the UnitedHealth Premium[®] program recognizes Network Physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

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For details on the UnitedHealth Premium[®] Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are available when you log onto **www.myuhc.com**;
- search for Network providers available in your Plan through the online provider directory;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports Covered Persons who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

For information regarding specific Benefits for cancer treatment within the Plan, see Section 5, *Additional Coverage Details* under the heading *Cancer Resource Services (CRS)*.

Condition Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a condition management program at no cost to you. The heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition. These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the condition management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
 - education about the specific disease and condition,
 - medication management and compliance,
 - reinforcement of on-line behavior modification program goals,
 - preparation and support for upcoming Physician visits,
 - review of psychosocial services and community resources,
 - caregiver status and in-home safety,
 - use of mail-order pharmacy and Network providers.

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Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealtheNotesSM

UnitedHealthcare provides a service called HealtheNotes to help educate Covered Persons and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 12, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Telephonic Wellness Coaching

The following provides a description of and the eligibility criteria for each Wellness Coaching program:

Weight Management Program

UnitedHealthcare's weight management program focuses on increasing your awareness of the benefits of proper nutrition and exercise, and helping you learn to manage your weight through behavioral modifications. UnitedHealthcare will identify Covered Persons who are eligible for the weight management program based on the following criteria:

- females (who are not pregnant) and males who are identified with a BMI of greater than or equal to 25.

Quitpower

As part of our wellness offerings, QuitPower is our advanced tobacco cessation program that focuses on specific measurable and attainable goals, such as establishing a quit date and avoiding triggers that lead to tobacco use. To deliver a highly engaging and personalized therapy, a single wellness coach will work with the participant for the duration of the QuitPower program. Through shared decision making, the coach and participant define a

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personalized plan with realistic, achievable goals, leading to freedom from tobacco. Nicotine Replacement Therapy (NRT), either patch or gum, is provided to qualified program participants, at no additional cost.

Stress Management Program

UnitedHealthcare's stress management program will provide you with information to help you manage stress through positive behavioral changes.

UnitedHealthcare will identify Covered Persons who are eligible for the stress management program based on the following criteria:

- Covered Persons who feel tense, anxious, or depressed often and stress has had a noticeable impact on health a lot over the past year.

Nutrition Management Program

UnitedHealthcare's nutrition management program will provide you with information designed to increase your awareness of the importance of proper nutrition, and setting dietary goals, and making lifestyle changes. UnitedHealthcare will identify Covered Persons eligible for the nutrition management program based on the following criteria:

- Covered Persons having a BMI of greater than or equal to 25 and less than 30 and 5-6 servings of high cholesterol food per day. BMI greater than or equal to 30 is prioritized to the weight management program.

Exercise Management Program

UnitedHealthcare's exercise management program will provide you with information to assist you in developing an appropriate exercise regime, giving consideration to factors such as age, weight and other health-related conditions. UnitedHealthcare will also provide exercise educational materials. UnitedHealthcare will identify Covered Persons eligible for the exercise management program based on the following criteria:

- Covered Persons with a BMI of greater than or equal to 25 and less than 30 and have physical activity less than one time per week. BMI greater than or equal to 30 is prioritized to the weight management program.

Heart Health Lifestyle Management Program (Blood Pressure/Cholesterol)

The heart health lifestyle management program provides you with an overall understanding of the factors that affect heart health, such as blood pressure and cholesterol. You receive assistance in making lifestyle changes to reduce risks, in addition to guidance on factors that increase risks, such as lack of proper nutrition and exercise. The identification/stratification criteria for the heart health lifestyle management program are as follows:

- self-report excess weight with a BMI > 25; or
- Covered Person has at least one of the following risk criteria:

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- systolic BP = ≥ 140 or Diastolic BP = ≥ 90
- high Blood Pressure and is on medication
- cholesterol = 240 or HDL < 40
- indicates has high cholesterol & is on medication
- high LDL
- indicates has heart problems, but no heart failure
- BMI greater than or equal to 30 is prioritized to the weight management program.

Diabetes Lifestyle Management Program

The diabetes lifestyle management program is designed to educate you on proper diet, weight loss/ management and exercise. You receive educational materials and guidance focused on prevention through diet, weight loss management, exercise and, when applicable, compliance with prescribed medication.

The identification/stratification criteria for the diabetes lifestyle management program are as follows:

- Covered Persons who indicate they have diabetes and self-report excess weight with a BMI > 25. BMI greater than or equal to 30 is prioritized to the weight management program.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 7 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 5, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 4, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 4, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the Benefit Booklet says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the Benefit Booklet specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing (holistic tissue massage).
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*.

This exclusion does not apply to Manipulative/Chiropractic Treatment and non-manipulative/chiropractic osteopathic care for which Benefits are provided as described in Section 5, *Additional Coverage Details*.

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Dental

1. Dental implants or root canals, orthodontic braces, removal of teeth and intra-bony cysts, procedures performed for the preparation of the mouth for dentures, except as identified under Dental Treatment Covered under Plan in Section 5, *Additional Coverage Details*. For information on coverage of removal of impacted wisdom teeth, refer to the Duke Energy Active Dental Plan SPD;
2. Treatment for the following conditions:
 - injury related to chewing or biting;
 - preventive dental care, diagnosis or treatment of or related to the teeth or gums;
 - periodontal disease or cavities and disease due to infection or tumor.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
3. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.
4. The replacement of lost or stolen prosthetic devices.
5. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details*.
6. Oral appliances for snoring.

Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill (See your Caremark Benefits Booklet for information about the Plan's prescription drug benefit).
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

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3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Clomiphine (e.g., Clomid[®]), menotropins (e.g., Repronex[®]), or other drugs associated with conception by artificial means.
6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services, unless the Plan has agreed to cover them as defined in Section 12, *Glossary*.

This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.

Foot Care

1. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.
 - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

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This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Arch supports.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies. Examples:
 - Compression stockings, ace bandages, diabetic strips, and syringes.

This exclusion does not apply to:

- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in Section 5, *Additional Coverage Details*.
 - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 5, *Additional Coverage Details*.
 - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 5, *Additional Coverage Details*.
2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.
 3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.
 4. The replacement of lost or stolen Durable Medical Equipment.
 5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 5, *Additional Coverage Details*.

Mental Health/Substance Use Disorder

In addition to all other exclusions listed in this Section 7, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services/Substance Use Disorder Services, Neurobiological Disorder - Autism Spectrum Disorder Services* in Section 5, *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance-related and addictive disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's Mental Illness, substance-related and addictive disorder or condition based on generally accepted standards of medical practice and benchmarks.
3. Mental Health Services as treatments for R, T and Z code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Mental Health Services as treatment for a primary diagnosis of insomnia, other sleep-wake disorders, sexual dysfunction disorders, communication disorders, motor disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder
6. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
7. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
8. Intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
10. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl Methadol), Cyclazocine, or their equivalents for drug addiction.
11. Gambling disorders.
12. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.

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13. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders.
4. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).
2. Food of any kind. Foods that are not covered include:
 - nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Food is covered only when the sole source of nutrition and administered via enteral feeding (tube feeding). Infant formula available over the counter is always excluded;
 - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
 - Oral vitamins and minerals.
 - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
 - Other dietary and electrolyte supplements.
3. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidentals for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.

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- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement;
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
- electric scooters;
- Exercise equipment and treadmills.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Medical alert systems.
- Motorized beds, non-Hospital beds, comfort beds and mattresses.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 12, *Glossary*. Examples include:
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Hair removal or replacement by any means.
 - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Skin abrasion procedures performed as a treatment for acne.
 - Treatments for hair loss.
 - Varicose vein treatment of the lower extremities, when it is considered cosmetic.
2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.

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3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.
5. Wigs regardless of the reason for the hair loss except for treatment of malignancy or permanent loss of hair from an accidental injury, in which case the Plan pays up to a maximum of \$500 per Covered Person per lifetime.
6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.
2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer).
3. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
4. Speech therapy to treat stuttering, stammering, or other articulation disorders.
5. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy* in Section 5, *Additional Coverage Details*.
6. Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy.
7. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
8. Psychosurgery (lobotomy).
9. Treatment of tobacco dependency, excluding screenings and counseling.
10. Chelation therapy, except to treat heavy metal poisoning.
11. Manipulative/chiropractic Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies

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12. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
3. Sex transformation operations and related services.
4. The following treatments for obesity:
 - Non-surgical treatment of obesity, even if for morbid obesity.
 - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 5, *Additional Coverage Details* and the other requirements described under *Obesity Surgery* in Section 5, *Additional Coverage Details*, are satisfied.
5. Medical and surgical treatment of excessive sweating (hyperhidrosis).
6. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.
17. Breast reduction surgery that is determined to be a Cosmetic Procedure.

This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 5, *Additional Coverage Details*.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services ordered or delivered by a Christian Science practitioner, acupuncturist or Doctor of Osteopathy.
4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.
5. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

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- Has not been actively involved in your medical care prior to ordering the service.
- Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue).
4. The reversal of voluntary sterilization.
5. Infertility and sexual dysfunction for dependent children.
6. Artificial reproductive treatments done for genetic or eugenic (selective breeding) Purposes.
7. Health services and associated expenses for elective surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).
8. Services provided by a doula (labor aide).
9. Parenting, pre-natal or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 9, *Coordination of Benefits (COB)*.
2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you.
3. While on active military duty.
4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

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Transplants

1. Health services for organ and tissue transplants except as identified under *Transplantation Services* in Section 5, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.
2. Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).
3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 5, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5, *Additional Coverage Details*.

Types of Care

1. Custodial Care or maintenance care as defined in Section 12, *Glossary* or maintenance care;
2. Domiciliary Care, as defined in Section 12, *Glossary*;
3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
4. Provider Concierge Services;
5. Private Duty Nursing received on an inpatient basis;
4. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details*;
5. Rest cures;
8. Services of personal care attendants;

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9. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.
3. Eye exercise or vision therapy.
4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
5. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices;

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.
2. Charges for:
 - Missed appointments.
 - Room or facility reservations.
 - Completion of claim forms.
 - Record processing.
3. Charges prohibited by federal anti-kickback or self-referral statutes.
4. Diagnostic tests that are:
 - Delivered in other than a Physician's office or health care facility.
 - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.
5. Expenses for health services and supplies:
 - That do not meet the definition of a Covered Health Service in Section 12, *Glossary*.
 - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
 - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.

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- For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan.
 - That exceed Eligible Expenses or any specified limitation in this Benefit Booklet
 - For which a non-Network provider waives the Annual Deductible or Coinsurance amounts.
6. Foreign language and sign language services.
7. Long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and
8. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.
- For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
9. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
- Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.
 - Related to judicial or administrative proceedings or orders.
 - Required to obtain or maintain a license of any type.
10. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

SECTION 8 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work.
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Deductible or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.myuhc.com, calling the toll-free number on your ID card or by visiting the Duke Energy Portal. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
 - The Current Procedural Terminology (CPT) codes.
 - A description of, and the charge for, each service.
 - The date the Sickness or Injury began.

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- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Duke Energy and the Plan reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes Duke Energy or the Plan pursuant to *Refund of Overpayments* in Section 9. *Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy

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for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the following:

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

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If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com. See Section 12, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

All claim forms for non-Network services must be submitted within 18 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 18 month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

This section describes what happens if a claim for Benefits is denied, how you can appeal a denied claim and the first and second level internal appeals processes. At the end of this section is a table which describes the time frames that you and UnitedHealthcare are required to follow in connection with the internal claims and appeals processes.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a concurrent claim determination, including a rescission of coverage, as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 740809
Atlanta, Georgia 30374

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

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Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal, and will take into account all comments, documents, records and other information you submit relating to your claim for Benefits, without regard to whether such information was submitted or considered in the initial denial. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

To the extent required by applicable law, UnitedHealthcare will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan (or at the direction of the Plan) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, to the extent required by applicable law, if the denial of your appeal is based on a new or additional rationale, UnitedHealthcare will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial. The written explanation will include the following:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination of your appeal;
- notification of the opportunity to request diagnosis codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- reference to the specific Plan provisions on which the determination of your appeal is based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information relevant to the claim;

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- a description of the Plan's external review procedures, the time limits applicable to such procedures and how to initiate the external appeal process;
- a statement regarding your right to sue under Section 502(a) of ERISA following any final internal adverse benefit determination and about any available voluntary alternative dispute resolution options;
- if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request;
- if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination. UnitedHealthcare must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and within 30 days after receiving the completed post-service appeal. Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial which will include the information specified above with respect to your first appeal, as well as the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. UnitedHealthcare's decision will be final, unless overturned through the Federal External Review Program described below.

Once you have exhausted the internal claims and appeals process described above, you may be able to file an appeal with an independent review organization (IRO) that is accredited to conduct external review. See "Federal External Review Program" below for additional information.

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Timing of Appeals Determinations

Separate schedules apply to the timing of claims and appeals, depending on the type of claim or appeal. There are three types of claims and appeals:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service claim - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	24 hours
You must then provide completed request for Benefits to UnitedHealthcare within:	48 hours after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	72 hours
If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal a denied Urgent Care request for Benefits.

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Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	5 days
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	15 days
You must then provide completed request for Benefits information to UnitedHealthcare within:	45 days
If UnitedHealthcare denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	15 days
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal the request for Benefits denial no later than:	180 days after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	15 days after receiving the second level appeal
Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	30 days
■ after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal the claim denial no later than:	180 days after receiving the denial

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UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you

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received UnitedHealthcare's decision. If you do not submit a request for standard external review within four months after the date you received UnitedHealthcare's decision, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was requested or provided.
- Did not have the claim denied due to a failure to meet the Plan's eligibility requirements.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is complete but is not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Department of Labor's Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials necessary to make the

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request complete. You must provide the required information to UnitedHealthcare within the original four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If you do not provide the required information by the applicable deadline, the claim will be deemed permanently waived and abandoned and you will be precluded from reasserting it under these procedures.

If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, the IRO considered in reaching its decision;
- a discussion of the principal reason or reasons for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;

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- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you as described above with respect to the Standard External Review process. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse

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benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Limitation of Action

You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. You cannot bring any legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator unless you first complete all the steps in the internal appeal processes described in this section. After completing this process, if you want to bring a legal action against the Company, the Plan, the Plan Administrator or the Claims Administrator, you must do so within one year following a final decision on the claim under the internal appeal processes or you lose any rights to bring such an action against the Company, the Plan, the Plan Administrator or the Claims Administrator.

SECTION 9- COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans.
- How coverage is affected if you become eligible for Medicare.
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.

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- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - The parents are married or living together whether or not they have ever been married and not legally separated.
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - The parent with custody of the child; then
 - The Spouse of the parent with custody of the child; then
 - The parent not having custody of the child; then
 - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples

- 1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
- 2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.

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- If this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary and the expense meets the definition of a Covered Health Service under this Plan, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older;
- individuals with end-stage renal disease, for a limited period of time; and
- participants not actively working and receiving long-term disability benefits for up to six months.

After a participant who is not actively working has received long-term disability benefits for six months, the Plan will pay Benefits second to Medicare.

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Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, for administrative convenience UnitedHealthcare in its sole discretion may treat the provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims if you are enrolled in Medicare and this Plan is secondary to your Medicare coverage (for example, if you are enrolled in this Plan under COBRA coverage or after receiving long-term disability benefits for six months). If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part A and Part B and DME carrier[s] have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

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Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the

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overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which UnitedHealthcare makes payments, with the understanding that UnitedHealthcare will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is alleged to be responsible.

Subrogation - Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Reimbursement - Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor (for example workers' compensation cases).
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

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You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
 - Providing any relevant information requested by the Plan.
 - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
 - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

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- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

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Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 11 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and the Company.
- Relationships with providers.
- Incentives to providers and you.

Your Relationship with UnitedHealthcare and the Company

In order to make choices about your health care coverage and treatment, the Company believes that it is important for you to understand how UnitedHealthcare interacts with the Plan and how it may affect you. UnitedHealthcare helps administer the Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- The Company and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions.
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this Benefit Booklet).
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between the Company, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not the Company's agents or employees, nor are they agents or employees of UnitedHealthcare. The Company and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees, agents or employees of Network providers.

The Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the Company and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but

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does not assure the quality of the services provided. They are not the Company's employees nor are they employees of UnitedHealthcare. The Company and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. The Company and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employee of the Company for any purpose with respect to the administration or provision of benefits under this Plan.

The Company and the Plan Administrator are solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination of or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as a participant responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.

Information and Records

UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. UnitedHealthcare may request additional information from you to decide your claim for Benefits. UnitedHealthcare will keep this information confidential.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan Administrator and UnitedHealthcare with all information or copies of records relating to the services provided to you. The Plan Administrator and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents. The Plan Administrator and UnitedHealthcare agree that such information and records will be considered confidential.

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The Plan Administrator and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the Plan Administrator is required to do by law or regulation. During and after the term of the Plan, the Plan Administrator and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements you should contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary.

UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

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Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but you should discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

The Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Company and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

SECTION 12 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this Benefit Booklet.

Many of the terms used throughout this Benefit Booklet may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Benefit Booklet, but it does not describe the Benefits provided by the Plan.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Annual Deductible (or Deductible) - the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year (other than Benefits for Network preventive care services which are paid at 100% by the Plan even before you satisfy your Annual Deductible). The Deductible is shown in the first table in Section 4, *Plan Highlights*.

Annual Enrollment - the period of time, determined by Duke Energy, during which eligible Employees may enroll themselves and their Dependents under the Plan. Duke Energy determines the period of time that is the Annual Enrollment period.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The BRS program provides:

- Specialized clinical consulting services to Covered Persons to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

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BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The CRS program provides:

- Specialized consulting services, on a limited basis, to Covered Persons with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 2, *How the Plan Works*.

Company - Duke Energy Corporation and its affiliated companies that are participating in the Plan.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health coverage to certain employees and their dependents whose group health coverage has been terminated.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

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Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Included in Section 4, *Plan Highlights* and Section 5, *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in the General Information Booklet.
- Not identified in Section 7, *Exclusions*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "Scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on www.myuhc.com or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on www.UnitedHealthcareOnline.com.

Covered Person – the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person. For purposes of the wellness programs described in Section 6, *Resources To Help You Stay Healthy*, "Covered Person" means all domestic Employees who are eligible for the Plan, their Dependents age 18 and over who are eligible for the Plan and each other person who is eligible for the Plan and elects to participate in the wellness program, regardless of whether such person also elects to participate in the Plan.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

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- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described in the General Information Booklet.

Designated Facility - a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions.

The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

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Eligible Expenses - Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by UnitedHealthcare as stated below and as detailed in Section 2, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accept.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or Substance Use Disorders which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Employee – an individual who meets the eligibility requirements described in the General Information Booklet.

Employer - Duke Energy Corporation.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

EOB - see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

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- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

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- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the Company. The KRS program provides:

- Specialized consulting services to Covered Persons with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

Manipulative/Chiropractic Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

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Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator - the organization or individual designated by the Plan Administrator who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 7, *Exclusions*.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 4, *Plan Highlights*, and Section 2, *How the Plan Works*, for details about how Network Benefits apply.

Non-Network Benefits - the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 4, *Plan Highlights*, and Section 2, *How the Plan Works*, for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - the maximum amount you pay every calendar year. Refer to Section 4, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 2, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

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Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Health Savings Plan 2 Option under the Duke Energy Active Medical Plan and/or the Duke Energy Active Medical Plan, as appropriate depending on context, each as amended from time to time.

Plan Administrator – The Duke Energy Benefits Committee or its designee.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

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- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 4, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services

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provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Benefit Booklet includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Spouse – your spouse or domestic partner as defined in the General Information Booklet.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Care - Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are supervised living arrangements which are residences that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program – a program that identifies network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

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To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center - a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- Do not require an appointment.
- Are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends.

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- Provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your Claims Administrator.



Prescription Drug Program Guide for the Duke Energy Active Medical Plan

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SECTION 1 – WELCOME

The Duke Energy Active Medical Plan (“Medical Plan”) options include outpatient prescription drug coverage currently administered by CVS Caremark. CVS Caremark works with Duke Energy Corporation (“Duke Energy”) (individually or collectively referred to with its affiliated companies as the “Company,” as appropriate) to help you improve your health and make informed health care decisions, as well as save money on your prescription drugs.

Your prescription drug program benefits through CVS Caremark include the following features:

- The CVS Caremark retail network consists of more than 64,000 participating retail pharmacies.
- Your long-term prescriptions can be delivered directly to you through the CVS Caremark Mail Service Pharmacy or picked up at a CVS retail pharmacy.
- Online resources are available at www.Caremark.com to order medications, check the status of your order(s), locate a participating pharmacy near you, and access useful health information.
- You can reach CVS Caremark Customer Service representatives, 24 hours a day, 7 days a week at 888-797-8912. Pharmacists are also available around the clock for medication consultations.

CVS Caremark will help protect your privacy as follows:

- CVS Caremark employees follow detailed ethical standards and a comprehensive Code of Conduct regarding your personal health information.
- CVS Caremark pharmacists follow a professional Code of Ethics.

SECTION 2 – HOW THE PROGRAM WORKS

Prescription Drug Coverage under the Health Savings Plan (HSP) Options

Because you are enrolled in a Health Savings Plan (HSP) option under the Medical Plan, you pay 100% of CVS Caremark's negotiated price for your prescription drug purchases (other than preventive medications, as described below) at retail pharmacies and through the CVS Caremark Mail Service Pharmacy until you meet the applicable Medical Plan annual deductible under your HSP option¹.

If you use a pharmacy that is participating in the CVS Caremark retail network, once you meet your applicable annual deductible, the HSP option pays eligible prescription drug expenses at 80% coinsurance and you pay 20% until you reach the applicable Medical Plan annual out-of-pocket maximum under the HSP option. If you use a pharmacy that is not participating in the CVS Caremark retail network, once you meet your applicable annual deductible, the HSP option pays eligible prescription drug expenses at 60% coinsurance and you pay 40% until you reach the applicable Medical Plan annual out-of-network, out-of-pocket maximum under the HSP option. The applicable annual out-of-pocket maximum under the HSP option is a combined out-of-pocket maximum that applies to both medical and prescription drug expenses under the Medical Plan. After you reach the applicable annual out-of-pocket maximum, the HSP option pays 100% of your eligible prescription drug purchases for the remainder of the calendar year.

If you use any medications on a long-term basis, ordering your medications through the CVS Caremark Mail Service Pharmacy may still help you maximize savings.

Remember: Under the HSP option, your eligible medical expenses and your eligible prescription drug purchase amounts apply to the HSP option's annual deductible and you pay 100% of your eligible expenses (excluding certain preventive care services and preventive medications) until you reach the deductible.

As you make prescription drug purchases for each covered individual, the receipts you receive can help you track your progress toward meeting the annual deductible. You may also call CVS Caremark Customer Service to determine the portion of the deductible that has been satisfied to date.

¹ For in-network benefits under the HSP option, you must satisfy an annual individual deductible if only you are covered or an annual family deductible if one or more of your eligible dependents also is covered.

Filling Your Prescription at a Pharmacy Participating in the CVS Caremark Retail Network

You can fill a prescription for up to a 30-day supply at any of over 64,000 retail pharmacies participating in the CVS Caremark retail network. You will simply show your CVS Caremark prescription ID card at the time of your purchase. You will pay 100% of your non-preventive prescription drug purchases until you meet the applicable Medical Plan annual deductible under your HSP option, after which you pay a coinsurance amount. Once you meet the applicable Medical Plan annual out-of-pocket maximum under your HSP option, the Medical Plan pays for your eligible prescription drug purchases at 100%.

- If you don't identify yourself to the pharmacist as a CVS Caremark participant, or if you go to a pharmacy that is not participating in the CVS Caremark retail network, you will have to pay the full price for non-preventive prescription drug purchases, even if you have already met the applicable Medical Plan annual deductible or annual out-of-pocket maximum under your HSP option, when you pick up the prescription and then submit a paper claim to CVS Caremark for reimbursement. You will be reimbursed based on the CVS Caremark negotiated price for the medication, less any required deductible and coinsurance. Retail pharmacies that participate in the CVS Caremark retail network fill prescriptions at an agreed upon discounted price. When you fill prescriptions at a non-participating retail pharmacy, or do not identify yourself as a CVS Caremark participant, you may be charged a price higher than the negotiated price and the result is a higher cost prescription to you.
- If you make a non-preventive prescription drug purchase at a pharmacy that is participating in the CVS Caremark retail network, do not identify yourself as a CVS Caremark participant by presenting your CVS Caremark prescription ID card and are required to pay full price for the non-preventive prescription drug purchase, generally, you have up to 14 days from the time your prescription was purchased to return to the pharmacy, present your CVS Caremark prescription ID card and ask the pharmacist to submit the order using the original dispensing date. Please confirm at the time you make your purchase that you can return to have your purchase re-processed. You may be entitled to a refund for the difference between the full price and your applicable deductible and coinsurance. This process will eliminate your need to submit a paper claim to CVS Caremark for reimbursement.

Using the CVS Caremark Maintenance Choice™ Program

Generally, a long-term (maintenance) medication is one that you take on a long-term basis such as those used for diabetes, asthma, high blood pressure, high cholesterol or birth control. If you are taking a long-term (maintenance) medication, you may request that your doctor prescribe 90-day supplies, plus refills as appropriate (three refills maximum) instead of 30-day supplies. Under CVS Caremark's Maintenance Choice program, if you choose to receive 90-day supplies, you must fill your prescription through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy near you.

Fill limit for long-term medications

The Medical Plan allows three 30-day fills of long-term medications at any pharmacy that participates in the CVS Caremark retail network. After that, the Medical Plan will cover long-term medications only if you have 90-day supplies filled through the CVS Caremark Mail

Service Pharmacy or at a CVS retail pharmacy at the applicable 90-day supply coinsurance amount. If you do not use the CVS Caremark Mail Service Pharmacy or a CVS retail pharmacy after the third fill, you will pay 100% of the retail price of the long-term medication.

Before you reach your 30-day fill limit and your out-of-pocket cost increases, CVS Caremark will contact you to help you get started with Maintenance Choice. CVS Caremark will help you get a 90-day prescription from your doctor so you can choose to fill it through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy.

If you will be obtaining your own prescription, ask your doctor for a prescription for up to a 90-day supply of medication, plus refills as appropriate (three refills maximum).

The list of long-term medications that are part of the Maintenance Choice program is subject to change at any time. Visit www.Caremark.com to find out whether your medication is considered a long-term medication and whether it is affected by any Medical Plan limits, or you may call CVS Caremark directly for more information.

Process for Mail Order Medications

To receive your long-term medications from the CVS Caremark Mail Service Pharmacy, complete the CVS Caremark Mail Service Order Form and send it to CVS Caremark, along with your original prescription(s) and the appropriate co-insurance amount for each prescription. Be sure to include your original prescription, as photocopies are not accepted. Call CVS Caremark to help you determine the required co-insurance amount for your prescription drug purchase. If you established an HSA and sufficient funds are in your account, you may use your HSA debit card or checkbook to pay for your CVS Caremark Mail Service Pharmacy purchases.

You can find a mail order form at www.Caremark.com, or you can call CVS Caremark Customer Service at 888-797-8912 to request a form. You also can find a mail order form on the Duke Energy Portal. Please complete the form, and mail it, along with the original prescription, to CVS Caremark. Keep a copy of the prescription for your records and allow a minimum of 10 to 14 business days for delivery.

Send mail order prescriptions to:
CVS Caremark Mail Service Pharmacy
P.O. Box 2110
Pittsburgh, PA 15230-2110

Please note: You must mail in a CVS Caremark Mail Service Order Form the first time you request a new prescription through mail service. You cannot use the available automated refill service until after your first prescription order has been processed by CVS Caremark.

You can also get started using the CVS Caremark Mail Service Pharmacy with FastStart[®]. FastStart[®] offers three convenient options for filling prescriptions for long-term medications:

Option 1: Internet

- a) Go to www.Caremark.com and sign in or register (if necessary). Click on “Start a New Prescription” and then click on “FastStart”.
- b) Fill in your:
 - Plan ID number (on your CVS Caremark prescription ID card)

- Prescription name
 - Doctor's name and phone number
 - Mailing address
 - Payment information
- c) CVS Caremark will contact your doctor to get a prescription for you.

Option 2: Phone

- a) Call FastStart toll-free at 800-875-0867.
- b) Provide your:
- Plan ID number (on your CVS Caremark prescription ID card)
 - Prescription name
 - Doctor's name and phone number
 - Mailing address
 - Payment information
- c) The CVS Caremark representative will contact your doctor and fill out the order form for you.

Option 3: Physician

- a) Give your doctor's office the toll-free FastStart physician number, 800-378-5697, and ask your doctor to call in the prescription for a 90-day supply.
- b) To expedite processing, your doctor will need the ID number from your CVS Caremark prescription ID card along with your date of birth and mailing address.

Please note: When a prescription is ordered using the CVS Caremark Mail Service Pharmacy, CVS Caremark will automatically dispense the generic equivalent if one is available and permissible by law, unless your physician has indicated that substitution is not allowed.

Using Mail Order if you have an Immediate Medication Need

If you will be using the CVS Caremark Mail Service Pharmacy, but need to begin taking a long-term medication immediately, have your doctor write two prescriptions:

- The first for up to a 30-day supply to be filled right away at any pharmacy that is participating in the CVS Caremark retail network – your doctor can call/fax this prescription to the pharmacy or provide it to you so you may take it to the pharmacy.
- The second for up to a 90-day supply to be filled through the CVS Caremark Mail Service Pharmacy using one of the methods described above.

Covered Expenses

The following are covered expenses under the Medical Plan unless listed as excluded below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles and Syringes
- Glucose Monitors
- Over-the-Counter (OTC) Diabetic Supplies (lancets, lancet devices, alcohol wipes)
- Oral, Transdermal, Intravaginal and Injectable Contraceptives
- Contraceptive Emergency kits
- Drugs to Treat Impotency (Limits of 6 units per 30 days at retail, and 18 units per 90 days at mail for all dosage forms except Yohimbine)
- Inhaler Assisting Devices
- Peak flow meters
- Fertility Agents (100% after deductible, if applicable, up to \$2,500 per person per lifetime, then participant pays 50% of the cost of the drug)
- Influenza treatments at 1 treatment course per 180 days
- Zyban and Chantix (limit of 360 days of therapy per lifetime)
- Anti obesity Agents
- Products packaged as greater than a 30-day supply are covered through the CVS Caremark Mail Service Pharmacy or at a CVS retail pharmacy only

Excluded Expenses

The following are excluded from coverage under the Medical Plan unless specifically listed as a benefit under "Covered Expenses."

- Non-Federal Legend Drugs
- Non-systemic contraceptives, devices
- Smoking Deterrents (except as listed above)
- Nutritional Supplements
- Ostomy Supplies (covered as a medical expense under the Medical Plan)
- Glucowatch Products
- Mifeprex
- Therapeutic devices or appliances (including Diabetic Pumps and supplies, which are covered as a medical expense under the Medical Plan)
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy Serums (covered as a medical expense under the Medical Plan)
- Biologicals, immunization agents or vaccines (except as noted below for certain routine vaccines)
- Blood or blood plasma products (covered as a medical expense under the Medical Plan)
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or from any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the participant

- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug

Medical Plan and Health Savings Account

If you have established a Health Savings Account and sufficient funds are available in your account, you may choose to pay any prescription drug annual deductible and coinsurance amounts with before-tax dollars by using your HSA debit card or checkbook.

Medical Plan and Health Care Spending Account

If you have enrolled in a Health Care Spending Account (HCSA) and are eligible to access HCSA funds, you may pay any prescription drug annual deductible and coinsurance amounts with before-tax dollars by filing for reimbursement from your HCSA or using your HCSA debit card.

SECTION 3 – COVERAGE DETAILS

CVS Caremark Primary/Preferred Drug List

Your cost for prescription purchases will vary depending on whether your physician prescribes a generic, preferred brand or non-preferred brand medication. By asking your physician to prescribe generic or preferred brand medications, you can help control rising health care costs.

Your prescription drug program incorporates a Primary/Preferred Drug List which lists the Medical Plan's preferred brand medications. The medications included on the list, which change from time to time, are commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings for the participant and the Medical Plan. For the most recent listing and to find out whether a medication is included in the Primary/Preferred Drug List, visit CVS Caremark online at www.Caremark.com or call CVS Caremark Customer Service at 888-797-8912. This listing is also available for viewing by employees on the Duke Energy Portal.

Refer to the prescription drug program summary of benefits on page 22 for more information about applicable coinsurance amounts for generic, preferred brand and non-preferred brand medications.

Preventive Medications

CVS Caremark maintains a list of certain medications prescribed to prevent the occurrence/re-occurrence of chronic illnesses. This list is referred to as the Preventive Therapy Drug List. Under your HSP option, preventive medications included on the Preventive Therapy Drug List are covered at 100% and are not subject to your HSP option's co-insurance or deductible when you use either a pharmacy that is participating in the CVS Caremark retail network or the CVS Caremark Mail Service Pharmacy to fill those prescriptions. This means that the Medical Plan will cover 100% of the cost and you will pay nothing, even if you have not met the applicable Medical Plan annual deductible.

Preventive medications are those items used to address risk factors for a disease that has not yet manifested itself, or to prevent the reoccurrence of a disease. Preventive medications do not include drugs for treatment of an existing illness or condition. A copy of the current Preventive Therapy Drug List is available on www.Caremark.com. CVS Caremark develops the Preventive Therapy Drug List in accordance with FDA and IRS guidelines regarding the types of medications that are considered "preventive" and therefore may be covered under your HSP option before the required deductible is satisfied. The Preventive Therapy Drug List is periodically updated to reflect new guidance issued and/or new drugs on the market.

Certain Contraceptive Medications Covered at 100%

The following contraceptive medications are covered at 100% (i.e., you do not pay anything when you purchase these items) when received from a pharmacy that is participating in the CVS Caremark retail network or the CVS Caremark Mail Service Pharmacy:

- Generic contraceptive medications; and

- Brand contraceptive medications where there is no generic available.

Note: If a generic version of a brand contraceptive medication becomes available, then only the generic contraceptive medication will be covered at 100%.

Certain Routine Vaccines Covered at 100%

The Medical Plan provides coverage for certain commonly administered vaccines at 100% when you present your CVS Caremark prescription ID card at a pharmacy that is participating in the CVS Caremark retail network. This is an alternative to getting certain immunizations from your doctor. Commonly administered vaccines available at a participating pharmacy through the Medical Plan include the following, where applicable:

- Hepatitis A (Adult)
- Hepatitis A (Child)
- Hepatitis B (Adult)
- Hepatitis B (Child)
- Human Papillomavirus (Gardasil)
- Influenza (Fluzone)
- Meningitis
- MMR (Measles, Mumps, Rubella)
- Pneumonia (Pneumovax)
- Polio (IPV)
- Shingles vaccine (Zostavax)
- TD (Tetanus, Diphtheria)
- Tdap (Tetanus, Diphtheria, Pertussis)

Please Note: Not all local pharmacies are staffed to provide immunizations and some may require a prescription to administer the vaccine based on requirements of particular states. Check with your local pharmacy for vaccine availability before you go.

CVS Caremark Specialty Medications and Specialty Guideline Management

Duke Energy participates in the CVS Caremark Specialty Guideline Management Program. This program supports safe, clinically appropriate and cost-effective use of specialty medications. Under your prescription drug program, some specialty medications may only be covered when ordered through CVS Caremark's specialty care pharmacy. CVS Caremark is dedicated to helping you meet the particular needs and challenges of using specialty medications, many of which require injection or special handling.

Certain specialty medications such as treatments for Growth Hormone and related disorders, Hepatitis C, Multiple Sclerosis and Anemia will have additional management that ensures that the specialty medication continues to have appropriate lab testing and data reviewed to help ensure utilization of these specialty medications to be:

- clinically appropriate;
- safe; and

- effective for the patient throughout the duration of therapy.

For continued treatment with one of these specialty drugs, a periodic clinical review is required. CVS Caremark will obtain the necessary clinical information from your doctor's office and conduct the review.

The CVS Caremark Specialty Pharmacy provides not only your specialty medicines, but also personalized pharmacy care management services:

- Access to an on-call pharmacist 24 hours a day, seven days a week
- Coordination of care with you and your doctor
- Convenient delivery directly to you or to your doctor's office
- Medicine- and disease-specific education and counseling
- Online support through **www.Caremark.com/specialty**, including disease-specific information and interactive areas to submit questions to pharmacists and nurses

If a covered participant uses medications that are classified by CVS Caremark as specialty medications and wishes to use the prescription drug benefit, the participant should obtain these medications from CVS Caremark Specialty Pharmacy Services. Most of these same drugs also require prior authorization from CVS Caremark, as described below. These drugs are typically only available in up to a 30-day supply, even if taken on a long-term basis.

All specialty medications undergo external review of the program guidelines by clinical experts to ensure the program is unbiased and consistent with current standards of care and practice.

To answer any questions you may have about specialty medications or to find out what medications are considered to be specialty medications for purposes of the Medical Plan, you may contact CVS Caremark Specialty Pharmacy Services directly at 800-237-2767.

SECTION 4 – SPECIAL PROGRAMS

Step Therapy Program

In order to have coverage for prescription medications in certain drug classes, you must try a generic medication first to treat your condition. If you try (or have tried) a generic medication and it does not work for you, then you may receive coverage for a preferred brand medication that your doctor prescribes. If you try (or have tried) a preferred brand medication and it does not work for you, then you may receive coverage for a non-preferred brand medication that your doctor prescribes.

The amount you pay for your prescription will be lowest when you choose a generic medication. If no generic is available – or if it is not right for you – your Medical Plan provides coverage for preferred brand medications, which may also save you money.

However, if you choose to use a preferred brand medication without trying a generic first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the preferred brand medication. If you choose to use a non-preferred brand medication without trying a generic and preferred brand first or without getting prior approval via the prior authorization process, coverage may be denied and you may have to pay the full cost of the non-preferred brand medication.

For information regarding the drug classes subject to the Step Therapy Program, call CVS Caremark at 888-797-8912.

Maximum Drug Limitation Program

The Medical Plan prescription drug benefits include quantity limits on certain medications, which are applied to address the problem of overuse of medications that can be unsafe for the patient. By following these guidelines, participants are assured of receiving the appropriate safe dosage recommended by the FDA. This means that:

- The Medical Plan will pay only for up to a specified quantity per 30- or 90-day periods.
- In addition, some medications have limitations on the day's supply of medication that may be dispensed to a patient at any one time.
- In certain drug classes, if the medical condition warrants a greater quantity than the established quantity limit, CVS Caremark will discuss the patient's needs with the patient's physician to determine if a greater quantity is medically necessary to treat the condition.

For information regarding the medications subject to the Maximum Drug Limitation Program, call CVS Caremark at 888-797-8912.

Prior Authorization

To ensure that drugs covered by the Medical Plan are used safely and appropriately, certain medications require that physicians obtain prior authorization from CVS Caremark *before* they are covered. Other classes may be added based upon safety, efficiency and FDA approved therapies. Call CVS Caremark at 888-797-8912 to determine if a medication requires prior authorization. Prior authorization does not guarantee coverage or payment under the Medical Plan.

Prior authorization also is required for a preferred brand medication to be covered prior to trying a generic medication, and for a non-preferred brand medication to be covered prior to trying a generic and preferred brand medication, as described above.

In order for medications which require prior authorization to be covered under the Medical Plan, your physician must obtain authorization from CVS Caremark at 800-294-5979 in advance of treatment with these medications.

Drug Utilization Reviews

Drug utilization reviews may help you guard against drug interaction problems that can occur, for example, when medications are prescribed by more than one physician. When your prescriptions are filled through the CVS Caremark Mail Service Pharmacy or at a pharmacy that is participating in the CVS Caremark retail network (using your CVS Caremark prescription ID card), they are reviewed for any potential drug interactions. This review is especially important if you or your covered family members take several medications or see more than one physician. If there is a question about your prescription, a registered pharmacist may contact your physician before dispensing the medication to discuss any alternatives and recommendations. You will be notified of any change in your prescribed medication. Your doctor makes the final decision on all of your prescription medications.

SECTION 5 – COORDINATION OF BENEFITS

Under the prescription drug program, CVS Caremark will not coordinate benefits for prescription drug expenses with other coverage you may have. That is, if you and/or your covered family members have prescription drug coverage under another plan, you may submit your prescription drug claims to whichever plan you choose. For example, if your spouse/domestic partner's medical plan does not cover prescription drugs or requires a higher deductible and coinsurance amount, you may want to use your CVS Caremark prescription ID card, instead of your spouse/domestic partner's plan, to obtain your prescriptions. Alternatively, if your spouse/domestic partner's medical plan requires co-pays to purchase prescription medications in lieu of deductibles and coinsurance, you may want to use your spouse/domestic partner's plan, instead of your CVS Caremark prescription ID card, to obtain your prescriptions.

SECTION 6 – CLAIMS PROCEDURES

How to File a Prescription Drug Program Claim

When you fill your prescription at a pharmacy that is participating in the CVS Caremark retail network and identify yourself as a CVS Caremark participant, you will not have to file a claim form. At the time your prescription is filled, you will have to pay the applicable deductible or coinsurance amount.

If you do not identify yourself to the pharmacist as a CVS Caremark participant, or if you do not use a pharmacy that is participating in the CVS Caremark retail network, you will need to file a claim for reimbursement of your prescription drug expenses through CVS Caremark. When you submit your claim, attach your original receipts and mail your claim to the address shown on the form. An original receipt should show the date of purchase, the name, cost, strength, quantity and days' supply of the medication, the prescription number and the NDC number. When you submit an original receipt, keep a copy for your records. Claim reimbursement is limited to CVS Caremark's discounted price less any required deductible and coinsurance.

CVS Caremark will consider claims for payment, provided your prescription claim is filed within 15 months from the date of service. Claims filed after 15 months from the date of service will not be considered for payment. For example, if you purchase a covered prescription medication on January 15, 2015, from a pharmacy that is not participating in the CVS Caremark retail network, you must file your claim by April 15, 2016 to receive reimbursement for your expenses.

If you are newly eligible, you have a 45-day grace period for prescription drug claims for purchases at full cost in situations where the prescription ID card was not used. The grace period allows participants to be reimbursed at 100%, less the applicable deductible and coinsurance, for paper claims submitted within 45 days from a participant's initial eligibility effective date with CVS Caremark. For example, a participant who's initial effective date with CVS Caremark is January 1, 2015 would have 45 days (until February 14, 2015) to submit a paper claim for medications purchased at full cost (no prescription ID card used) regardless of whether or not the pharmacy was participating in the CVS Caremark retail network.

To obtain a claim form, call CVS Caremark Customer Service at 1-888-797-8912, or go online to **www.Caremark.com**.

Submit claim forms to:
CVS Caremark
P.O. Box 52196
Phoenix, AZ 85072-2196

Reviews & Appeals

The timing for review of your claim depends on the type of claim you submit, as described below. You may designate an authorized representative to assist you with the claims and appeals process described below.

Review Timing for Post-Service Claims

In the case of a post-service claim, CVS Caremark will notify you of the determination within 15 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CVS Caremark's control, it will notify you within 15 days after receiving the request. The extension notice will include a description of the circumstances requiring the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the request.

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

For these purposes, a post-service claim is any claim that is not a pre-service claim or an urgent care claim, each as defined below.

Review Timing for Pre-Service Claims (Claims Relating to Prior Authorization)

In the case of a pre-service claim, CVS Caremark will inform you of its decision (whether adverse or not) within a reasonable period of time appropriate to the medical condition, but not later than 15 days after it receives the claim. Under special circumstances, CVS Caremark may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which CVS Caremark expects to render a decision.

If additional information is needed because necessary information is missing from the request, the notice will specify what information is needed. You must provide the specified information to CVS Caremark within 45 days after receiving the notice. The determination period will be suspended on the date CVS Caremark sends a notice of missing information and the determination period will resume on the date you respond to the notice.

If you have not followed the proper procedures for filing your pre-service claim, you will be notified of the failure and the proper procedures to be followed in filing pre-service claims. This notice will be provided to you as soon as possible, but not later than 5 days, following the failure. This notification may be oral, unless you request written notification.

For these purposes, a pre-service claim means any claim for a benefit with respect to which the terms of the prescription drug program condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Review Timing for Urgent Care Claims

If your claim is an urgent care claim, CVS Caremark will notify you of its decision on your claim (whether adverse or not) as soon as possible, but no later than 72 hours after it receives the claim. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable, CVS Caremark will inform you as soon as possible, but no later than 24 hours after it receives the claim, of the specific information necessary to complete the claim. You will have a reasonable amount of time, taking into account the circumstances, but no less than 48 hours, to provide the specified information. CVS Caremark will notify you of its determination on your claim as soon as possible, and no later than 48 hours after the earlier of (1) CVS Caremark's receipt of the specified information and (2) the end of the period provided to you to provide the specified additional information.

If you have not followed the proper procedures for filing your urgent care claim, you will be notified of the failure and the proper procedures to be followed in filing urgent care claims. This notice will be provided to you as soon as possible, but not later than 24 hours, following the failure. This notification may be oral, unless you request written notification.

For these purposes, an urgent care claim is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Notice of Adverse Determination

In the event of an adverse benefit determination, in whole or in part, you will be notified of the adverse determination in writing.

An adverse benefit determination is a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Medical Plan benefit. An adverse benefit determination notification for any prescription drug program claim will contain:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the prescription drug program's internal review procedures, the time limits applicable to such procedures and how to initiate an appeal, including a statement of your rights to bring a civil action under section 502(a) of ERISA following any final internal adverse benefit determination on appeal;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate an external appeal;
- a statement that a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim is available free of charge upon request;
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims;

- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals process.

If the adverse benefit determination relates to an urgent care claim, the information described above may be provided to you orally within the required time frame, provided that a written or electronic notification is provided no later than 3 days after the oral notification.

When You Have a Complaint or an Appeal

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

- your name and participant ID number;
- your doctor's name and telephone number;
- the name of the medication; and
- any additional information from your pharmacy or medical provider that will assist CVS Caremark in completing its review of your appeal, such as documents, records, questions or comments.

Documents, records, written comments, and other information in support of your appeal should accompany your request. This information will be considered by CVS Caremark in reviewing your claim. You may request reasonable access to copies of all documents, records, and other information relevant to your claim. CVS Caremark will review your claim without granting any deference to the initial decision regarding your claim. Also, no reviewer may be a person that was involved in making the initial decision regarding your claim, or a subordinate to that person. If the claim was based, in whole or in part, on a medical judgment in reviewing the claim, CVS Caremark will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person (or a subordinate of a person) consulted by CVS Caremark in deciding the initial claim. Your appeal should be mailed to:

Caremark, Inc.
Department of Appeals, MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

CVS Caremark can also be reached by fax at 866-689-3092. In the case of an appeal relating to an urgent care claim, you may request an expedited appeal orally by contacting CVS Caremark

at 888-797-8912 or in writing. All necessary information will be transmitted by telephone, fax or other available similarly expeditious manner.

To the extent required by applicable law:

- you will be allowed to review your claim file and to present evidence and testimony as part of the internal claims and appeals process;
- CVS Caremark will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the prescription drug program (or at the direction of the prescription drug program) in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date; and
- if the denial of your appeal is based on a new or additional rationale, CVS Caremark will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you will have a reasonable opportunity to respond prior to that date.

Timing of Appeal Notification for Post-Service Claims

In the case of a post-service claim, CVS Caremark will notify you of its decision on your appeal within 30 days of its receipt of your request for review.

Timing of Appeal Notification for Pre-Service Claims (Claims Requiring Preauthorization)

In the case of a pre-service claim, CVS Caremark will provide notification of its determination on appeal within a reasonable amount of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

Timing of Appeal Notification for Urgent Care Claims

In the case of an urgent care claim, CVS Caremark will provide notification of its determination on appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request for review.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- information sufficient to identify the claim involved;
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- a description of the prescription drug program's external review procedures, the time limits applicable to such procedures and how to initiate the external appeals process;
- a statement describing any voluntary appeal procedures offered by the prescription drug program and your right to bring an action under ERISA section 502(a) following any final internal adverse benefit determination;

- a statement that copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal are available upon request and free of charge;
- notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- a statement that if the adverse determination is based on medical necessity or experimental treatment, or a similar exclusion or limit, you will be provided, upon request and free of charge, an explanation of the scientific or clinical judgment, applying the terms of the prescription drug program to your medical circumstances; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Second Level Appeal Process for Post-Service Claims

If your post-service claim is denied on appeal, you have a right to bring a second appeal within 30 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in “When You Have a Complaint or Appeal” above. CVS Caremark will notify you of its decision on your appeal within 30 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in “Notice of Benefit Determination on Appeal” above, as well as the following statement: “You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

Second Level Appeal Process for Pre-Service Claims

If your pre-service claim is denied on appeal, you have a right to bring a second appeal within 15 days of the adverse benefit determination on the first level appeal. A second appeal should contain the information and should be submitted to the address described in “When You Have a Complaint or Appeal” above. CVS Caremark will notify you of its decision on your appeal within 15 days of your request for a second review. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include the information listed in “Notice of Benefit Determination on Appeal” above, as well as the following statement: “You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

Voluntary External Review Program

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

If you wish to file a request for external review, you must submit your request within 4 months of the date of your receipt of CVS Caremark’s final internal adverse determination on your

appeal. Contact CVS Caremark at the telephone number shown on your CVS Caremark prescription ID card for more information on how to file a request for external review of your appeal.

CVS Caremark will determine if your appeal is eligible for the voluntary external review program and will provide you with a written notice of its determination. If your request is complete but not eligible for external review, the notice will include the reason or reasons for the denial and contact information for the Employee Benefits Security Administration. If your request is not complete, the notice will describe the information or materials needed to make the request complete, and, in order to pursue an external review, you must provide the required information within the 4-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

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

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

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

If your request for external review relates to an urgent care claim, CVS Caremark will determine if the appeal is eligible for the voluntary external review program and will provide you with written notice of its determination immediately. If the urgent care claim is eligible for external review, CVS Caremark will assign the urgent care claim to an IRO as described above. The IRO will review all of the information and documents relevant to the appeal, to the extent the information and documents are available and the IRO considers them appropriate. The IRO will provide notice to you and the Medical Plan of the final external review decision as soon as possible, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not provided in writing, the IRO will provide you and the Medical Plan with a written confirmation of its decision within 48 hours after the date of providing the notice.

Legal Action

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

Discretionary Authority

The authority to decide initial claims for prescription drug program benefits under the prescription drug program and denied claims for prescription drug benefits on review under the prescription drug program includes the full power and discretion to interpret prescription drug program provisions and to make factual determinations, with CVS Caremark's decisions, interpretations and factual determinations controlling, unless overturned through the voluntary external review program described above. Requests for information regarding individual claims, or a review of a denied claim, are to be directed in writing and properly addressed to CVS Caremark at the address listed above. Call CVS Caremark Customer Service for additional information regarding the appeals process.

This is a guide of covered expenses and expenses not covered under the prescription drug program. This guide contains selected highlights of Duke Energy's employee benefits plans. If any statement herein, or any other communication, conflicts with the applicable plan documents, the plan documents will govern. Duke Energy retains the right to amend, modify or terminate its benefits plans in any respect and at any time, and neither its benefits plans, nor your plan participation, will be considered a contract for future employment. For more information about applicable deductibles, coinsurance and plan limits, please call CVS Caremark Customer Service or visit www.Caremark.com. For more detailed information on the Medical Plan, refer to the Duke Energy Active Medical Plan General Information Booklet and UnitedHealthcare[®] Benefits Booklet sections of this Summary Plan Description.

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SECTION 7 – PRESCRIPTION DRUG BENEFIT SUMMARY

	CVS Caremark Retail Pharmacy Network For short-term medications (up to a 30-day supply) you pay:	Maintenance Choice[®] CVS Caremark Mail Service Pharmacy or CVS Retail Pharmacy For long-term medications (up to a 90-day supply) you pay:
Preventive Medications Includes certain contraceptive medications and routine vaccines	\$0	\$0
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	20% of medication cost (after your deductible has been met)	20% of medication cost (after your deductible has been met)
Preferred Brand Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from the CVS Caremark Primary/Preferred Drug List.	20% of medication cost (after your deductible has been met)	20% of medication cost (after your deductible has been met)
Non-Preferred Brand Medications You will pay the most for medications not on the CVS Caremark Primary/Preferred Drug List.	20% of medication cost (after your deductible has been met)	20% of medication cost (after your deductible has been met)
Refill Limit	None	None
Annual In-Network Deductible The deductible is a combined medical and prescription drug deductible.	\$1,500 per year for individual coverage / \$3,000* per year for family coverage	
Out-of-Pocket Maximum** The out-of-pocket maximum is a combined medical and prescription drug out-of-pocket maximum.	\$3,500 per year for individual coverage / \$7,000*** per year for family coverage	

*The deductible is a true family deductible. The full \$5,000 amount must be reached before the Medical Plan pays any benefit for any covered member of the family (other than in-network benefits for certain preventive care services and preventive medications, including certain contraceptives and routine vaccines).

**Amounts you pay to satisfy the deductible and amounts you pay as co-insurance are applied toward your out-of-pocket maximum and are included for purposes of determining whether you have reached your out-of-pocket maximum.

***Not to exceed \$6,850 for any one individual.

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